

# **John B. Semiannual Progress Report**

## **July 31, 2004**

The state has continued and implemented many EPSDT activities. Each child serving state department or division has participated in the EPSDT effort under the guidance of the Governor's office and has actively coordinated efforts to best serve children.

Each department/division involved in the EPSDT program also spent a significant amount of time and resources on the Special Master's Itemized Assessment Protocol (IAP) and Work Plans (IWP). On March 22, 2004 and June 2, 2004, the State submitted a coordinated response to the Itemized Assessment Protocol, and submitted work plans on February 20, 2004 and June 21, 2004.

This report was also a coordinated effort and reflects the EPSDT activities by department/division which together form the State of Tennessee's EPSDT program.

Highlights of activities during the past six months include the following:

- Creation of the Governor's Office of Children's Care Coordination- an office with a full-time director and staff with sufficient time, authority, and experience to manage the EPSDT program across departments
- Planning of a new TENNderCARE outreach campaign and trainings across the state
- Continued provision of at least 5,000 EPSDT screens per month by local health departments across the state
- The dental screening percentage (DSP) during the first year of the dental carve-out increased by 28.3%
- Dental provider networks grew by 81% since September 2002 and 86% of participating providers were currently accepting new TennCare patients
- Statewide the enrollee to provider ratio for children ages 3 through 20 was 747:1 as compared to the ratio used under the Terms and Conditions for Access in the Waiver, where the patient load is given as 2,500:1
- The number of teeth sealed on TennCare children by the Health Department increased by 22%
- The APSP increased from 42% to 56%, an increase of 33%. The CMS 416 report documented an increase in the screening rate from 54% in 2002 to 62% in 2003, a 14.8% increase. The Medical Record Review results showed the documentation of the 7 components increased from 77.7% to 90.4%, an increase of 19%
- Children enrolled in Nashville Connection experienced a 37% drop in episodes of residential care from baseline to 12 months

Sections of this report and the pages on which they begin are as follows:

|   |    |
|---|----|
| Part I: Outreach and Screening Paragraphs 39-52 .....   | 2  |
| Part II: Diagnosis and Treatment Paragraphs 53-77 .....   | 24 |
| Part IV: Coordination and Delivery of Services to Children in State Custody Paragraphs 84-93..... | 34 |
| Part V: Monitoring and Enforcement of MCO and DCS Compliance Paragraphs 94-103.....               | 37 |

## **Part I: Outreach and Screening Paragraphs 39-52**

### **A. Outreach**

EPSDT outreach occurs through the MCO's, through other states agencies such as DCS and the health department, and through contracts with outside agencies such as the Tennessee Homeless Coalition.

#### **TENNderCARE**

EPSDT theme brainstorming sessions were conducted with internal and external EPSDT stakeholders utilizing research on children's health messages. The theme name and layout of "TENNderCARE" was developed and approved by the outreach work group, Governor's appropriate staff, and Commissioners.

**New EPSDT/TENNderCARE brochure:** Draft of the new EPSDT brochure was approved and a plan is in place for the creation of the additional materials using the new theme such as posters, appointment cards, and web site.

The new brochure has been tested with child advocates and in field testing at the Department of Health. In addition to being used as the general brochure for EPSDT, the new brochure will be included in the registration packet for every child in public school. This brochure will also be used by the DOH community outreach workers in providing education to TennCare families. A corresponding logo has been developed and will be used with the outreach "products" such as brochures, notification letters, appointment cards, web-site, etc. and an inventory has been conducted to identify all TennCare materials that need to use the TENNderCARE name.

**New EPSDT/TENNderCARE brochure for Teens:** In addition to the brochure mentioned above, a brochure is being developed for teenagers to encourage them to seek preventive health care. The brochure will be targeted to appeal to teens with its look and presentation.

**Posters, Appointment Cards, and other "marketing items":** A color poster (mainly for use at community activities and health fairs) will be developed along with an electronic version of a black and white poster that

can be downloaded from the website. Appointment cards with the TENNderCARE logo will be developed and distributed to physicians'/providers' offices and local

health departments. There is discussion of other items that could be used to promote awareness of TENNderCARE, e. g., band-aids with the logo or health message.

**Baseline survey of EPSDT awareness:** A phone survey of TennCare families will be conducted to develop a baseline for EPSDT awareness. Subsequent surveys will be conducted to determine impact and effectiveness of outreach activities.

**TENNderCARE Website:** A website is being developed for TENNderCARE and will contain information for families, teens, and providers about benefits available to children through the TENNderCARE program. Downloadable brochures and posters will be available at the website. The website will contain helpful numbers, web-links, and other information that should be valuable to TennCare families, advocates, providers, teachers, churches, and agencies that serve children

**Media Campaign:** A media campaign will be launched to promote awareness of TENNderCARE. Both TV and radio will be used with at least one spot being targeted directly to teenagers. It is likely that other public space will be used such as: bus benches, billboards, etc. The campaign is expected to precede the implementation of the call center and community outreach project.

**TENNderCARE Call Center:** The Department of Health will staff a centralized call center to contact TennCare families with enrolled children to provide outreach, benefits education, and appointment scheduling assistance.

**TENNderCARE Community Outreach Project:** The Department of Health will implement a community outreach approach that would use community lay workers to reach TennCare families and provide outreach, benefits education, and appointment scheduling assistance. The project also includes working with other community agencies and leaders to promote EPSDT.

## **TennCare MCO Marketing Materials**

MCO marketing materials must receive prior approval in order to ensure compliance with marketing guidelines. During the past six months the following submissions were reviewed by TennCare:

XXXXXX=Files are still outstanding and revisions have been requested

| <b>MCO Name</b>   | <b>Document Name</b>  | <b>Date Received</b> | <b>Date Approved</b> | <b>Revisions</b> |
|-------------------|---|----------------------|----------------------|------------------|
| Better Health     | Childhood/ Adolescent 2004 Immunization Schedule/ Web Link          | 2/11/04              | 2/18/04              | No               |
| Better Health     | Fayette County Public Health Week                                   | 3/22/04              | 4/2/04               | No               |
| Better Health     | Immunization 2004 Schedule (July-Dec) for Website                   | 6/3/04               | 6/7/04               | No               |
| Better Health     | 2004 Summer Member Newsletter B.Well Today                          | 6/11/04              | 6/22/04              | No               |
| Better Health     | 2004 Member Handbook  | 6/30/04              | XXXXXX               | Yes              |
| BlueCare          | 2004 Spanish Member Newsletter                                      | 1/15/04              | 2/06/04              | Yes              |
| BlueCare          | 2 <sup>nd</sup> Quarter 2004 Member Newsletter                      | 3/26/04              | 4/12/04              | Yes              |
| BlueCare          | Spanish 2 <sup>nd</sup> Quarter 2004 Member Newsletter              | 4/14/04              | 4/27/04              | Yes              |
| BlueCare          | CareManagement PrePrinted Educational Brochures (12)                | 5/28/04              | 6/7/04               | No               |
| Doral Dental      | Member 2004 Educational Newsletter                                  | 1/5/04               | 1/20/04              | No               |
| Doral Dental      | Doral Initiative #2 Outreach Postcard and Member Dental Call Script | 4/26/04              | 5/17/04              | Yes              |
| Doral Dental      | TennCare Member Handbook (English)                                  | 4/29/04              | 5/7/04               | No               |
| John Deere Health | Winter 2004 Newsletter Healthy Talk                                 | 2/23/04              | 3/9/04               | No               |
| John Deere Health | 2004 TennCare Member Handbook Addendum                              | 3/16/04              | 4/14/04              | Yes              |
| John Deere Health | Spring 2004 Health Talk Member Newsletter                           | 3/31/04              | 4/15/04              | Yes              |

| <b>MCO Name</b>   | <b>Document Name</b>   | <b>Date Received</b> | <b>Date Approved</b> | <b>Revisions</b> |
|-------------------|--|----------------------|----------------------|------------------|
| John Deere Health | 2004 Member Handbook Addendum (Revised)  | 6/30/04              | 7/13/04              | No               |
| OmniCare          | EPSDT Member Outreach Letters  | 1/28/04              | 1/29/04              | No               |
| OmniCare          | Spring 2004 Member Newsletter  | 2/10/04              | 2/24/04              | No               |
| OmniCare          | OCHP 2004 Member Handbook  | 3/3/04               | 3/30/04              | Yes              |
| OmniCare          | OCHP 2004 Fall Newsletter (EPSDT)  | 6/17/04              | XXXX                 | Yes              |
| OmniCare          | Member Emergency Room Letter, EPSDT Reminders Letters, Coloring Books & Calendar | 4/2/04               | 4/15/04              | No               |
| OmniCare          | 2004 Summer Member Newsletter  | 4/8/04               | 4/15/04              | No               |
| PHP TennCare      | 1 <sup>st</sup> Quarter 2004 Take Five Newsletter                                | 2/27/04              | 4/8/04               | Yes              |
| TennCare Select   | 1 <sup>st</sup> Quarter 2004 Living Healthy Newsletter                           | 3/4/04               | 3/30/04              | Yes              |
| TennCare Select   | 2 <sup>nd</sup> Quarter 2004 Member Newsletter                                   | 3/26/04              | 4/12/04              | Yes              |
| TennCare Select   | 2004 Spanish Member Newsletter   | 1/15/04              | 2/6/04               | Yes              |
| TennCare Select   | Spanish TennCare Select Source 2 <sup>nd</sup> Quarter 2004 Member Newsletter    | 4/14/04              | 4/27/04              | No               |
| TennCare Select   | Care Management Pre-Printed HealthCare Educational Brochures (12)                | 5/28/04              | 6/7/04               | No               |
| TLC               | EPSDT Program Survey   | 2/2/04               | 2/03/04              | No               |
| TLC               | Member Spring 2004 Newsletter  | 1/14/04              | 2/3/04               | Yes              |

| <b>MCO Name</b> | <b>Document Name</b>                             | <b>Date Received</b> | <b>Date Approved</b> | <b>Revisions</b> |
|-----------------|--|----------------------|----------------------|------------------|
| TLC             | Spanish 2004 Spring Member Newsletter            | 2/11/04              | 3/12/04              | Yes              |
| TLC             | 2004 Summer Healthy Now Newsletter               | 5/14/04              | 5/27/04              | No               |
| TLC             | Spanish Summer 2004 HealthyNow Member Newsletter | 6/1/04               | 6/22/04              | Yes              |
| VHP             | 2004 Winter Healthy Living Newsletter            | 2/17/04              | 2/20/04              | No               |
| VHP             | Spring 2004 Healthy Living Newsletter            | 5/7/04               | 5/14/04              | No               |

### **TennCare Policy / Advocacy Update**

- Weekly meetings continue to be held with the TennCare Advocates by TennCare Policy leadership staff to discuss enrollee/applicant issues, TennCare program changes, eligibility modifications, and operational issues such as TennCare medical or administrative appeals. Concerns voiced by the Advocacy community are shared with the Bureau Director and other Executive staff to resolve problems/issues.

These meetings continue to be effective in establishing and maintaining positive working relationships with the advocacy community. They serve to provide early resolution to problems the enrollees/applicants are experiencing. Advocates receive early briefings on potential program/benefits changes that assist them in understanding program activity and/or changes that will impact their consumers. Additionally, input is sought from the advocates on potential changes to the program and their recommendations are considered.

- Policy leadership staff continues to meet with advocates individually as requested to work through outstanding program or operational issues.
- Work groups continue to meet on various topics that arose from the September 2003 advocates meeting with Governor's Office staff, Commissioners from various Departments, and the TennCare Bureau Deputy Commissioner that discussed streamlining the TennCare eligibility process and the TennCare appeals process. Many of their comments that were taken under advisement are still under discussion today. In particular, a recommendation to begin using

enrollment facilitators has been actively researched, with a target date of January 2005 to begin a pilot project on this topic.

## **DCS EPSDT Outreach Activities**

### **Educating DCS Case managers**

DCS Health Units provide on the job training for new DCS case managers regarding TennCare Access and Advocacy, including EPSDT, eligibility, and appeals. Regional administrators have been informed to ensure that the Health Units receive an opportunity to discuss TennCare information, including EPSDT and appeals, at regional meetings at least on a quarterly basis.

Since March 2004, the following regional trainings have occurred:

- Mid Cumberland region Health Advocacy provided 6 appeals trainings in May, and 6 appeals trainings in June. These were to DCS staff, and CSA staff. Provider training was given to a contract agency on July 1, 2004.
- East Region Health Advocacy provided Notice of Action and Permanency Planning training on 6/15, 6/21, 6/22, 6/28, and 6/29. Permanency Planning training includes education on EPSDT screenings, and the incorporation of those screening results into the Permanency Plan.
- Upper Cumberland Health Advocacy provided training on Appeals and Notice of Action on 6/16/04. This includes notification on service decisions (EPSDT) for children in care.
- Knox Health Advocacy trained on Notices of Action and the Permanency Plan on 5 occasions in May/June. ( May 10, June 8, June 22, July 7<sup>th</sup>, and July 28).
- NW Health Advocacy TennCare Rep trained staff on the SAT, advocacy contractors, EPSDT, and filing appeals on 5/12, 5/18, and 6/22/04.
- Hamilton county Health Advocacy TennCare Reps trained regarding Notices of Actions, Appeals, the SAT, and filing appeals 10 times in May/June.( 5/27, 6/2, 6/3, 6/4, 6/10, and 6/15, 6/22, 6/24, 6/25, and 6/29).
- NE Region Health Advocacy provided training on appeals and the Services/Appeals Tracking (SAT) on March 17<sup>th</sup>, April 20<sup>th</sup>, and May 18<sup>th</sup>.

The Central office Health Advocacy also provided the following trainings regarding EPSDT services for children in care:

- Mary Beth Franklyn, Vicki Peterson, Diana Yelton, and Tricia Henwood, provided review of policy, appeals, and advocacy to Health Units on April 7 and 8 at the Health Unit conference.
- Mary Beth Franklyn reviewed the appeals process with Regional Administrators on April 7, 2004, and provided an update with questions and answer opportunity in the Regional Administrator phone conference on April 30, 2004.
- Vicki Peterson facilitated a phone conference with TennCare Reps on May 7, 2004.
- Mary Beth Franklyn and Vicki Peterson provided training to Davidson county Health Units, Team Leaders, and other regional leadership on 6/8/04.
- Mary Beth Franklyn and Vicki Peterson provided training to Shelby county Health Unit, Team Leaders, and other regional leadership on 6/10/04.

An additional training tool for all DCS staff includes “DCS Alls” emails containing TennCare Tips which are published approximately once a week.

- A TennCare Tip regarding coordinating services for children on EPSDT during the summer months was published on 6/1/04, which reminded case managers to file appeals on denied services.
- A TennCare Tip regarding outpatient BHO services and appointments was published on 6/28/04, which reminded case managers to file appeals on denied or non accessible services.
- A TennCare Tip regarding EPSDT screenings and coordination with the PCP was published on 7/22/04.

Further information and education was provided in an article on Due Process and Appeals rights (Grier compliance) and the Child and Family Team Meeting process, that was published in the Weekly Wrap Up, a statewide DCS released newsletter. The article was published on May 14. On July 2, 2004 an article in the Weekly Wrap Up educated regarding EPSDT, and informed case managers about current screening rates.

- DCS also coordinates to ensure that Foster Parents receive information about TennCare Services and EPSDT. Mary Beth Franklyn provided information on EPSDT and appeals to Betty Hastings, the coordinator of the Foster Parent Advocates, during the month of June to provide to foster parent advocates at training. Ongoing PATH training for new foster parents across the state includes EPSDT and Appeals information. In addition, DCS has arranged for TennCare Select to be included in the Statewide Foster Parent



Conference Oct. 10, 2004. They will give a brief presentation and have a booth.

## **Department of Health EPSDT Outreach Activities**

### **Outreach/Advocacy**

Outreach and Advocacy activities are provided to TennCare-eligible citizens by all 95 county health departments. This is in accordance with an inter-department contract that has been in place for ten years.

Services offered by health department staff in the advocacy role include:

- Information and education to families on the importance of preventive health care
- Assisting with appointments to providers
- Assisting with appeals when services are denied, especially for children with special health care needs

### **Community Outreach**

The Department of Health has recently entered into a \$6.615 million contract with the Bureau of TennCare to implement a community outreach project. This will be an effort to increase awareness of the availability and importance of EPSDT services. This project will be a significant expansion of EPSDT services and will be targeted to a broader population of enrollees than those who are seen in the local health department clinics. The project will have specific components designed to reach teens. The statewide project will use community health council coordinators and lay outreach workers to provide outreach and education services to families with TennCare children, TennCare teens and young adults, TennCare providers, and community leaders.

The Department is also planning to implement an EPSDT outreach call center that will phone TennCare families who have children eligible for EPSDT screening services. The outreach operators will provide education regarding the importance of preventive services; offer assistance in scheduling EPSDT appointments with either the child's primary care provider or the local health department; offer assistance with other TennCare issues; and document the outcome of the call. The call center will be staffed with twelve managed call operators and one bilingual operator. This staff will work extended hours in an effort to reach working families.

## **Department of Education- Outreach**

The following reflects EPSDT related activities conducted through the nine district offices of Tennessee's Early Intervention System (TEIS). This system serves children birth to three years of age with disabilities.

May 2004: Dr. Ruth Allen and Dr. Quentin Humberd provided training to all TEIS Project Coordinators on the State's START initiative. TEIS follow-up support will include direct collaboration with START personnel in local implementation including assisting with and participating in training activities.

June 2004: All TEIS District Offices began routinely including the EPSDT Periodicity Schedule in all TEIS Intake Packets. Of the intakes conducted by TEIS offices between January and June of 2004, 1,542 were eligible for TennCare.

## **Division of Mental Retardation Services- Outreach**

### **Advocacy**

The Division of Mental Retardation (DMRS) Central Office notified the Intake Coordinators at each of the three regional offices about the importance of educating families requesting services from the Home and Community Based (HCBS) waiver about EPSDT services. The coordinators and the Intake Specialists are familiar with the TennCare website and use that information to help families access services in the community.

### **EPSDT Community Outreach Project**

The DMRS Central Office Early Intervention Director has provided two trainings with current EPSDT materials to the Early Intervention provider groups in Middle and West Tennessee. They are aware that an EPSDT Community Outreach Project is planned for fall, 2004 and that DMRS will supply them with updated materials at that time.

### **Covered and Non-Covered Services**

The DMRS Central Office Early Intervention Director and distributed the list of covered/non-covered services to the Intake Offices and the Early Intervention programs so that may better advise families of entitled benefits. All of these personnel have been encouraged to attend training in their areas when it is available.

## **Tennessee Chapter of the American Academy of Pediatrics (TNAAP) Activities**

The Bureau of TennCare has contracted with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). The primary purpose of this grant is to identify barriers to and improve compliance with the EPSDT screening requirements and associated screening performance standards. Current areas that TNAAP is working on with TennCare include:

## **1. Office Visits/Trainings:**

- Conducted 16 introductory office visits (combined total of offices represent approximately 68 physicians)
- Conducted 55 expanded office visits/trainings (combined total of offices represent approximately 335 physicians), including three mock EPSDT audits, one coding audit, and seven formal training sessions
- TNAAP EPSDT Director attended Knoxville Pediatric Society Meeting on June 16 and promoted EPSDT and Coding educational services available
- Held booth at National Immunization Conference (3 day conference at Opryland with approximately 300 participants)
- Completed exhibit paperwork for Tennessee Academy Family Practice (TAFP) annual conference (December 1 to 3 in Chattanooga)
- Assisted various providers through multiple phone calls and emails with EPSDT coding and billing information.

(See **Attachment A** for a summary of office visits, training sessions and regional events/conventions.)

## **2. Development/Distribution of Educational Materials:**

- The EPSDT and Coding Brochure was mailed to the entire TNAAP membership with a cover letter advising them of resources available
- Winter newsletter included COE article, and an update on 2004 codes along with photos of EPSDT Director and Coding Educator at regional EPSDT/Coding program
- 2004 Pediatric Coding Brochure was updated and reprinted
- EPSDT forms revised
- Ongoing distribution of educational packets to physician offices continues through office visits (packets include brochure, sample forms, EPSDT Book, Pediatric Coding Book, etc.)
- Continued work on draft of a child car seat safety brochure (describing new law), which includes a section on the importance of preventive health screens (promoting EPSDT services). This will be made available to all TNAAP pediatricians for use in their offices
- Obtained approval from AAP for TNAAP to use Universal hearing form – clarified questions about approval and provided contact info to state so they may request same
- Began work on revising website to make it more “user-friendly” and expand information available related to EPSDT

### **3. Developmental/Behavioral Screening Educational Campaign:**

- Conducted various meetings with TNAAP physician advisors and TennCare administration regarding program components
- Developed project proposal, draft Scope of Services and associated budget and obtained contract expansion from TennCare
- EPSDT Director presented proposal overview at MCO/BHO Medical Director's Meeting
- Continued interaction with TNAAP Board of Directors regarding project
- Set up and conducted panel to assist Early Intervention staff in improving communication with physician offices - Presented power point presentation introducing developmental behavioral screening initiative to group
- Developmental Behavioral Medical Director met with statewide Interagency Council to discuss concept – he will participate in their retreat in April to discuss further how we can work together on this Project
- Hired Developmental Services Coordinator
- Finalized program and secured expert speakers for a comprehensive Developmental/Behavioral Health CME program in November 2004.
- TNAAP EPSDT Director and Medical Director met with TEIS Coordinators from across the state. Provided program overview and discussed how organizations will work together on educating physicians about referral resources
- Continued development of educational program to be offered by TNAAP
- Participation in screening guidelines committee

### **4. Dialogue with Henry Ireys of Mathematica/Establishment of Work Groups**

- Dr. Ireys met with TNAAP EPSDT Director and state staff to discuss work groups and create a work group plan.
- TNAAP EPSDT Director chaired multiple meetings of the Provider Education and Participation (PEP) work group

### **5. Feedback regarding Audit Tool/Process:**

- Provided feedback to Audit department on recommendations for changes/revisions/clarifications on new audit tool. Tool was revised and redistributed by TennCare Quality Oversight.

#### **6. Mock Audits and Coding Training for MCO EPSDT Coordinators:**

- Completed development of four hour program (Mock Audit and Coding Educational sessions) for January 12, 2004 meeting of EPSDT Coordinators. TNAAP Coding Educator and Joel Bradley, MD presented program, TNAAP EPSDT Director provided TNAAP Overview
- Developed follow-up program at request of group for April 26, 2004 meeting; presented mock EPSDT audit program (after incorporating changes to audit tool) and training on 2004 pediatric codes

#### **7. Dialogue/Outreach With Other Professional Organizations:**

- Interactions with and presentations to TEIS
- Arranged to participate in annual meeting of Tennessee Academy of Family Physicians (TAFP) in fall, 2004
- Dialogue with TAFP re: obtaining approval for continuing education accreditation for Family Practice physicians Developmental/Behavioral programs

### **Children's Policymakers Work Group (CPWG)**

The Children's Policymakers Work Group met every two weeks at TennCare to plan quarterly statewide video conferences and a statewide Policymakers' Seminar.

This group has set up a meeting for August 11, 2004 with Manny Martins of the Governor's Office of Children's Care Coordination to discuss how the group can support the activities of his new office. The video conferences will also be discussed as an outreach avenue.

On April 23, 2004, the workgroup conducted the Fourth Annual Policymaker's Discussion on Children's Health. Dr. Andres J. Pumariega, Director of ETSU Center of Excellence presented a discussion on Becoming Culturally Sensitive in Providing Health Care for Hispanic Children and Families. The breakout sessions included Coordinated System of Care and Medical Home, Strengthening the Safety Net for Children, and Mental Health and State Custody Concerns. In the afternoon there was an open panel which included Linda O'Neal, from the Tennessee Commission on Children and Youth and other dignitaries from child serving state departments.

The Children's Policymakers Work Group is currently planning the Fifth Annual Policymakers' Discussion on Children's Health tentatively scheduled for April 08, 2005 at the Nashville Public Library.

## **TennCare Shelter Enrollment Project**

### **Project Description**

The TennCare Shelter Enrollment Project is an outreach demonstration project supported by a grant from the Department of Housing and Urban Development (HUD) Emergency Shelter Grant Program, administered by DHS, and matched by the Bureau of TennCare, Tennessee Department of Finance and Administration. The project was initiated in 1998 by the National Health Care for the Homeless Council to improve the health of homeless children in Tennessee by increasing their access to health insurance coverage and primary care.

Our target population was children residing in selected homeless and domestic violence shelters across the state between July 1, 2003 and June 30, 2004. Thirty-one emergency shelters- participated in project activities during 2003-2004. Six shelters that participated last year were unable to do so this year; nevertheless, there were more than twice as many participants in 2003-2004 as in 1998-1999 (14). Selection criteria were interest in participation and capacity to collect and report information about the insurance status of homeless children served and use of primary and preventive care services by those enrolled in TennCare.

### **Activities to improve access to EPSDT services**

- **EPSDT Outreach and Collaboration with Local Health Departments**

During FY 2004, the project maintained consultation with 24 local health departments in all three Grand Divisions of the state (West, Middle, and East) and worked with them to design EPSDT informational flyers targeting sheltered homeless children for outreach and education about preventive health services available under TennCare. The project utilized a community-based approach to improve homeless families' awareness of EPSDT benefits and how to make screening appointments at local health departments for their children. The project coordinator developed and disseminated a total of 370 EPSDT flyers to 35 emergency shelters and

homeless service providers to inform homeless families how to obtain EPSDT services at local health departments for children residing in Tennessee emergency shelters.

In addition, efforts were made to increase access to preventive health services for homeless children and youth. The project coordinator collaborated with TennCare medical and dental providers to develop innovative outreach approaches to expedite access to EPSDT services for sheltered homeless children. Safety net providers were consulted to facilitate linkages with emergency shelters. As a result, the project was successful in facilitating EPSDT outreach to 7 Memphis/Shelby County shelters through mobile health clinics that provided onsite delivery of health services to homeless children.

- **Train-the-Trainer Workshops**

During FY 2004, 3 train-the-trainer workshops were conducted in each grand region of the state. A total of 107 participants attended these one-day workshops, conducted in Nashville, Knoxville and Memphis. Attendees included speakers and representatives from community-based organizations (CBOs), TennCare MCO/BHO EPSDT Coordinators, emergency shelter staff, homeless persons, DHS offices, local health departments, Community Mental Health Centers, PATH Programs, homeless advocates, Legal Aid, safety-net agencies, and regional homeless coalitions.

Workshop trainers and presenters described the special primary and preventive health care needs of homeless children and explained the benefits of preventive care and how EPSDT services help to detect and treat health problems early. Train-the-trainer workshops also provided opportunities for MCO/BHO EPSDT coordinators and local health department staff to work with emergency shelter staff in developing community-based EPSDT outreach activities to educate and inform homeless families about how to obtain preventive health services for their children.

**Train-the-Trainer Workshops Conducted In FY 2004**

| <b>Region</b> | <b>Training Date</b> | <b>County</b> | <b>Location</b>          | <b>Attendance</b> |
|---------------|----------------------|---------------|--------------------------|-------------------|
| Middle        | 9/26/03              | Davidson      | Lentz Health Center      | 41                |
| East          | 11/21/03             | Knox          | Knox County Health Dept. | 32                |
| West          | 5/7/04               | Shelby        | Community Foundation     | 34                |
| <b>Total</b>  |                      |               |                          | <b>107</b>        |

- **Toll Free Shelter Health Line**

The toll-free Shelter Help Line, established in 2002 to provide information about TennCare enrollment and EPSDT services to eligible low-literacy homeless persons, remained operational between July 1, 2003 and June 31, 2004. During FY 2004, the project coordinator received 56 telephone requests for assistance on from sheltered homeless individuals and families or their advocates.

- **TennCare Access Networks (TANs)**

These TennCare stakeholder groups meet regularly in four regions of the state to work collaboratively, share the latest information about TennCare/EPSDT policies, examine strategies to inform homeless families about preventive health care, and participate in community-

based outreach activities to facilitate access to TennCare services for eligible homeless children. TAN meetings are usually co-facilitated by a representative of the homeless service community and a TennCare or safety net service provider. Participants (usually 10–15 people per meeting) include shelter staff, other homeless service providers, consumer advocates, representatives of state and local agencies — TennCare MCCs, local health departments (LHDs), LEP agencies, TennCare Advocacy agencies, Community Health Center (CHCs), Community Mental Health Centers (CMHCs) and PATH programs, and Community Access Programs (CAPs). The project coordinator provides up-to-date TennCare enrollment and EPSDT information to TAN participants for dissemination to other staff and homeless clients and offers technical assistance and support. Topics covered included: development of EPSDT flyers for outreach to homeless families, MCC EPSDT shelter outreach, EPSDT access and health benefits for homeless children, mental health services for homeless families, mobile clinics, TennCare dental coverage and access, and Spanish speaking persons' access to TennCare EPSDT services.

In addition, efforts were made to increase access to preventive health services for homeless children and youth. The project coordinator continued to develop, in consultation with TennCare medical and dental providers, innovative outreach approaches to ensure that sheltered homeless children obtain expedited access to EPSDT services. “Safety-net” providers were consulted in an effort to facilitate linkages between those agencies and emergency shelters. As a result, the project coordinator initiated discussions in April 2004 with two mobile outreach service providers in order to increase access to EPSDT services for sheltered homeless children. Consequently Well Child Health Screening program and Smith Wilson & Associates Mobile Dental Services agreed to collaborate with the project and provide onsite EPSDT services for selected emergency shelters located in the Memphis Shelby County area. During the current reporting period, a total of 54 homeless children have obtained EPSDT and dental services through this mobile outreach effort with 2 of the 5 shelters targeted for this innovative EPSDT outreach initiative.

## **Outcomes**

### **TennCare Children with Preventive or Primary Care Visits**

FY 2003 – FY 2004:

- 15% decrease in percentage of sheltered homeless children with a sick-child visit
- 46% increase in percentage of sheltered homeless children with a well-child check-up
- 4% increase in percentage of sheltered homeless children with a preventive or primary care visit



- 38% decrease in number of reported sick-child visits by sheltered homeless children
- 5% increase in number of reported well-child visits by sheltered homeless children
- 25% decrease in number of total visits to a primary care provider by sheltered homeless children

**Percentage of TennCare Children Served with a Primary/Preventive Care Visit: FY 2003 vs. FY 2004**

| <b>Visit to Primary Care Provider</b> | <b>7/02 – 6/03</b> | <b>7/03 – 6/04</b> | <b>% change</b> |
|---------------------------------------|--------------------|--------------------|-----------------|
| primary care (sick-child)             | <b>22% (299)</b>   | 19% (184)          | -15%            |
| preventive care (well-child)          | <b>10% (130)</b>   | 14% (140)          | 46%             |
| Total (sick-child + well-child)       | <b>32% (429)</b>   | 33% (324)          | 4%              |
| Total children served                 | 1,676              | 1,205              |                 |

**Number of Primary/Preventive Care Visits by Children on TennCare: FY 2003 vs. FY 2004**

| <b>Visit to Primary Care Provider</b> | <b>7/02 – 6/03</b> | <b>7/03 – 6/04</b> | <b>% change</b> |
|---------------------------------------|--------------------|--------------------|-----------------|
| primary care (sick-child)             | 299 (70%)          | 184 (58%)          | -38%            |
| preventive care (well-child)          | 130 (30%)          | 140 (43%)          | 5%              |
| Total PCP encounters                  | 429                | 324                | -25%            |

Fifty-eight percent (184) of reported primary care encounters in 2003-04 were “sick-child” visits, and 43 percent (140) were “well-child” check-ups, representing a 15% decrease in the percentage of reported sick child visits since last year and a 49% increase in the percentage of well child visits. West Tennessee shelters reported the highest percentage of well-child visits (24%) in 2003-04, compared to 8% reported by Middle Tennessee shelters and 7% reported by East Tennessee shelters.

## B. Screening

The Department of Health clinics conducted 32,935 EPSDT screenings during the period covered for this semi-annual report.

The chart below indicates the activity for each of the thirteen public health regions.

| EPSD&T Screens January - June, 2004 |           |           |           |           |           |           |             |
|-------------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Region ▼                            | YR ▼ MON  |           |           |           |           |           | Grand Total |
|                                     | 2004      |           |           |           |           |           |             |
|                                     | January   | February  | March     | April     | May       | June      |             |
|                                     | Tot Units | Tot Units | Tot Units | Tot Units | Tot Units | Tot Units |             |
| Blountville/Sullivan Region         | 56        | 69        | 92        | 76        | 70        | 73        | 436         |
| Chattanooga/Hamilton Region         | 118       | 121       | 145       | 108       | 92        | 135       | 719         |
| East Tennessee Region               | 322       | 316       | 409       | 378       | 325       | 307       | 2,057       |
| Jackson/Madison Region              | 78        | 63        | 112       | 75        | 67        | 69        | 464         |
| Knoxville/Knox Region               | 336       | 296       | 368       | 320       | 283       | 311       | 1,914       |
| Memphis/Shelby Region               | 748       | 911       | 1,181     | 922       | 819       | 771       | 5,352       |
| Mid Cumberland Region               | 557       | 478       | 651       | 480       | 461       | 429       | 3,056       |
| Nashville/Davidson Region           | 58        | 61        | 109       | 102       | 80        | 73        | 483         |
| Northeast Region                    | 625       | 588       | 814       | 721       | 582       | 567       | 3,897       |
| South Central Region                | 314       | 325       | 461       | 468       | 373       | 410       | 2,351       |
| Southeast Region                    | 198       | 179       | 222       | 234       | 225       | 304       | 1,362       |
| Upper Cumberland Region             | 382       | 341       | 531       | 464       | 386       | 440       | 2,544       |
| West Tennessee Region               | 1,452     | 1,295     | 1,428     | 1,433     | 1,321     | 1,371     | 8,300       |
| Grand Total                         | 5,244     | 5,043     | 6,523     | 5,781     | 5,084     | 5,260     | 32,935      |

Every effort is made to be compliant with providing the seven-component screening. If this is not possible for any reason, it is documented in the patient record and in the letter sent to the primary care physician.

## Health Department screening services

### Dental Activities

The effort begun in the spring of 2001, to improve access to dental services for low-income Tennessee children, has continued. The Tennessee Department of Health (TDH) has continued to expand its dental program. Specifically, clinical dental programs were enhanced through one-time special needs grants; preventive dental services provided statewide through a contract with TennCare which funds the School Based Dental Prevention Program are continuing; and at this time three mobile dental clinics are fully operational providing comprehensive dental services to children in remote underserved areas. These three mobile dental clinics are located in Northeast, Mid-Cumberland, and in the West Tennessee regions.

Dental special needs grants were awarded to 22 counties. These one-time funds were used for renovation or upgrading existing dental facilities and for new dental construction. Projects have been completed in 18 of the 22 counties. The Blount and Hamblen County Health Departments completed their new dental clinics during this reporting period.

## **Oral Disease Prevention Program- School Based Dental Prevention Program**

This program is a statewide school based preventive dental program targeting children in grades K-8 in schools with 50% or more free and reduced lunch. These preventive services are offered to all children in the targeted schools. Portable equipment is used by dental staff to provide dental screenings and sealants to this population. Referrals for all children with unmet dental needs are made. The initial screenings are provided to all children in the school and no information concerning TennCare status is available at this juncture in the program. Health education, oral evaluations, and preventive sealants are offered to all children in the target school as well as information regarding TennCare eligibility and the application process. Oral evaluations and sealants require parental consent. Using the information provided on the consent TennCare enrollment is validated to allow for TennCare-specific reporting.

The figures for January, 2004-June 2004 are noted in the table below. The total number of children (TennCare and non-TennCare) screened was **76,440** with **21,990** being referred for unmet dental needs. **18,447** TennCare children had a comprehensive oral evaluation and **11,603** received sealants. TennCare Outreach was provided to **78,532** children statewide during this time period.

### **Statewide School Based Dental Prevention Program January 2004- June 2004**

|                                      | <b>Number of<br/>Schools</b> | <b>Number of Teeth</b> | <b>Number of<br/>Recipients</b> |
|--------------------------------------|------------------------------|------------------------|---------------------------------|
| <b>General<br/>Screening</b>         | <b>202</b>                   |                        | <b>76,440</b>                   |
| <b>Referred for<br/>Treatment</b>    |                              |                        | <b>21,990</b>                   |
| <b>Periodic Oral<br/>Evaluations</b> | <b>184</b>                   |                        | <b>18,447</b>                   |
| <b>Dental Sealants</b>               | <b>184</b>                   | <b>164,449</b>         | <b>25,774</b>                   |
| <b>Oral Health<br/>Education</b>     |                              |                        | <b>93,818</b>                   |
| <b>TennCare Outreach</b>             |                              |                        | <b>78,532</b>                   |

**School- Based Dental Prevention Program  
TennCare – specific Data  
January 1, 2004- June 30, 2004**

| <b>Services</b>  | <b>Recipients/Services</b> |
|--|----------------------------|
| <b>Oral Evaluations for children with TennCare</b>         | <b>18,447</b>              |
| <b>Number of children with TennCare receiving sealants</b> | <b>11,603</b>              |
| <b>Number of teeth sealed on children with TennCare</b>    | <b>81,573</b>              |

**Mobile Dental Clinics:** Three mobile dental clinics have been purchased by the Bureau of Health Services of the Tennessee Department of Health. All three clinics have operated this year providing comprehensive services to children in school settings. The Mid-Cumberland mobile clinic has been outfitted with teledental capabilities which will allow for consultations with University of Tennessee dental faculty in cases where referral to a specialist might be indicated. For January- June 04, **5** schools received dental services from the mobile dental clinics this year. A total of **80** children with TennCare made **208** visits to the mobile dental clinics and received over **513** dental services. These dental services included cleanings, x-rays, fluoride treatments, fillings, and extractions.

## **TennCare Quality Oversight**

### **TennCare Medical Record Review**

Calculation of the annual APSP for federal fiscal year 2003 ending September 30, 2003 was completed in June. The APSP increased from 42% to 56%, an increase of 33%. The CMS 416 report documented an increase in the screening rate from 54% in 2002 to 62% in 2003, a 14.8% increase. The Medical Record Review results showed the documentation of the 7 components increased from 77.7% to 90.4%, an increase of 19%. Analysis of the medical record review for seven EPSDT components was completed in June. All seven components of the medical record showed improved documentation for 2003. Areas showing the most improvement were patient history (52% increase), unclothed physical (24% increase) and hearing screen (14% increase). A total of 450 charts were included in the study. Fifteen (3.3%) of the 450 charts could not be located and these charts were scored as non-compliant for all seven components.

The CMS 416 report was submitted to CMS in May. All age categories showed improvement in the screening rates with the greatest percentage increases occurring in the 19-20 age group (33%), the 6-9 age group (15%) and the 15-18 age group (13%).

Additional analysis is needed to better understand the key drivers of these increases and pinpoint additional opportunities for improvement.

The managed care organizations continue to submit monthly and quarterly outreach reports identifying their outreach efforts for unscreened children for TennCare's review.

### **TennCare EPSDT Dental Activities**

Covered dental services under TennCare rules include preventive, diagnostic and treatment services to enrollees under age (21) twenty-one. Procedures defined by Current Dental Terminology (CDT-4) codes are covered for children as medically necessary.

Based on the parameters established by TennCare, as well as enrollee-to-dentist ratios, analysis indicates that child enrollees have good access to dental care. Although there is no "universally accepted" population-to-dentist ratio, TennCare has compared our ratio to the number used under Terms and Conditions for Access in the Waiver, where the patient load is given as 2,500:1 or less for physicians and dentists. In April 2004, TennCare had a ratio of 747 child enrollees ages 3 through 20 to each participating dental provider.

TennCare has also historically utilized the GeoNetworks "capacity" report to analyze waiver compliance. GeoAccess analysis revealed no deficiencies in the network at ratios of 2,500:1 or at half of that ratio 1,250:1. Based on a GeoAccess parameter of 2,500:1, the average distance from a TennCare enrollee to a participating dental provider was 3.8 miles. At a ratio of 1,250:1 the average distance was 4.6 miles.

In accordance with the specific instructions provided in paragraph 46 of the John B. Consent Decree as it relates to dental, TennCare has calculated the dental screening percentage (DSP) for FFY 2003 to be 45.8%. In FFY 2002, the year prior to the dental carve out, the DSP was 35.7%. Therefore, during the first year of the dental carve out there was over a 28% increase in the DSP.

From October 1, 2002 through April, 2004, the dental provider network has grown by 81% from 386 unduplicated dental providers to 700 unduplicated providers. Surveys reveal that approximately 86% of participating dentists are actively accepting new TennCare patients into their practices indicating that the existing capacity to treat TennCare children has not yet been exceeded.

At the most recent TennCare Dental Advisory Committee Meeting on April 2, 2004, representatives of the Tennessee Dental Association and the Pan Tennessee Dental Association indicated that they were not aware of any dental access issues related to TennCare enrollees.

Since July 1, 2001, a partnership between the Bureau of TennCare and the Tennessee Department of Health has resulted in the provision of statewide oral disease prevention services for children in public elementary schools at high risk for dental caries. Services include dental screening, referral, follow-

up, sealant application, oral health education, oral evaluation and dental outreach.

## **Screening Guidelines Committee**

The EPSDT Screening Guidelines Committee was reconstituted and retained as many members as were available and willing to serve from the 1998-1999 committee. Their charge was to review and update the screening guidelines for vision, hearing, and developmental/behavioral services. The first meeting of the committee occurred on October 2, 2003, with subsequent meetings on October 23, 2003, November 13, 2003, December 11, 2003. The work of that committee was presented to David O. Hollis, M.D., Chief Medical Officer, TennCare, on December 18, 2003. It included the final vision and hearing screening guidelines, as well as optional dental screening guidelines. The recommended changes were consistent with the AAP Periodicity Schedule. There were enhancements made to the screenings but no reduction in frequency. A subcommittee of the committee has been meeting to finalize recommendations regarding the developmental tool and training. The Committee made final recommendations to Dr. Hollis. The Developmental/Behavioral Screening Guidelines Subcommittee to finalize the document, along with a training/educational component from the Tennessee Chapter of the American Academy of Pediatrics (TNAAP), before bringing it back to the reconvened entire Screening Guidelines Committee for final review, revision, and/or approval. All screening guidelines were reviewed and approved David O. Hollis, M.D., CMO and forwarded to the Deputy Commissioner of TennCare for review by the Governor's EPSDT Coordinating Committee.

Provider Services developed a plan of education for providers that participated in the 7th Annual Stewart County Health Fair on 4/24/04. TennCare was invited to participate by the Stewart County Health Department and the Stewart County Coordinated School Health Program, co-sponsors of the event. Educational materials were distributed to approximately 350 members and providers.

## **Division of Mental Retardation Services- Screening**

### **Provision of EPSDT screening services in local health departments**

The DMRS Central Office Early Intervention Director has notified the DMRS regional office Intake Office and the Middle and West Tennessee early intervention providers about the provision of EPSDT screening services in the local health departments.

### **Primary Care Services**

DMRS provided service to 309 TennCare children in the HCBS Medicaid waiver and 2373 children in early intervention in 2003-04, 70% of which were TennCare eligible children. All of those children had to have a physical

to participate in the program. This is a requirement of the TMH/DD licensure for all programs funded by DMRS.

### **Immunizations**

All children who are receiving HCBS waiver services and early intervention services through DMRS must have up to date immunizations in order to participate in the program. This is a requirement of the TMH/DD licensure for all programs funded by DMRS.

## **Part II: Diagnosis and Treatment Paragraphs 53-77**

### **Centers of Excellence**

The three Centers of Excellence for Children (COEs) are located at East Tennessee State University (ETSU), the University of Tennessee at Memphis (UT-M) and Vanderbilt University (VU). The Centers of Excellence for Children

were created to augment existing capacity in providing direct and ancillary medical and behavioral health services to children in, and at risk of state custody. The COEs support DCS in integrating placement, family, health and developmental needs into a comprehensive and coordinated care plan based on the child and family's unique needs. The COEs provide direct services as well as comprehensive record reviews, consultation, training, and follow-up.

Since their inception the COEs have served a total of 1698 children. During the past six months, the COEs have triaged 373 referrals and seen 242 children directly. In addition, in the past six months, the COEs have provided over 200 medication management services and 242 tele-health sessions.

During the past six months the COEs continued to assess the quality of their services and to provide opportunities for continuous improvement of their services. Two new quarterly studies were initiated: 1) A follow-up to recommendations study and 2) A Peer Review Quality Improvement study.

**Follow-up to Recommendations Study:** The first project is a follow-up study of the implementation of recommendations made by the COEs. Monitoring follow-up is an important primary function of the COEs. Two analyses of data from different quarters were completed this past six months. In the initial study, covering a three month period ending in February, 2004, 80% of all COE recommendations were found to have been implemented. A second analysis, for the quarter ending May 31, 2004, was completed in June. During the second quarter of analysis, COEs demonstrated an overall 5% improvement rate from the previous quarter. All COEs improved over baseline. In the interest of continuous improvement, COEs are currently engaged in an analysis of barriers to implementation of recommendations. The results of this study will be examined to determine how implementation of recommendations can be further improved.

As part of this process, COE staff have also started asking DCS staff to rate the effectiveness of services. The most recent results from this survey indicate that 100% of the DCS case workers have found COE services to be beneficial, with 99% of the respondents rating the consultation/evaluation as a "4 or 5" on a five point scale (five being the highest).



**Peer Review:**

During the spring of 2004 the COEs also began a peer review process of cases. Two quarterly reports have now been completed.

The Peer Review Project is designed to provide a systematic and professional review of processes and outcomes of the clinical services provided by Tennessee's Centers of Excellence for Children in State Custody.

Professionals for each COE review case records from the other COEs and direct feedback is given to the staff of the COE. Using the Review Summary Form, reviewing COE personnel answer qualitative questions for each case regarding intake, evaluation, and recommendations. The focus of the reviews is on how COE clinical functions support specific outcomes of *safety*, *permanence*, and *physical and emotional well being* of the child and family. Among the strengths and areas for improvement cited in the report:

**Strengths:**

- 1) Generally, reviewers found that sufficient records were obtained and that the COEs are addressing important child welfare concerns such as safety, permanence and physical and emotional well being in evaluations.
- 2) Reviewers noted that the COEs are providing comprehensive services and working closely with DCS and service providers.
- 3) Reviewers noted that records obtained were comprehensive and included past evaluations, mental health records, DCS records, school records, court records, and medical records. In addition to record collection, in most cases COE staff had made contact with treatment providers and in one case, extensive contact with the caregiver was documented.
- 4) Comments from the reviewers included praise for the thoroughness, scope, and clarity of the recommendations. Most reviews noted that appropriate, specific recommendations for treatment, placement, school services, and medical follow-up had been made.
- 5) The immediacy with which acute needs were addressed was commended.

**Areas for Improvement:**

Each COE received feedback about their particular evaluation process and recommendations. Based on this feedback, COEs are modifying their procedures for how they perform evaluations and consultations. The feedback included:

- 1) Findings indicate that COE evaluations are viewed as thorough and comprehensive and include extensive input from other providers, caregivers and past records. At times, accessing additional records would be advisable in a number of cases. For instance, it was thought that it would be useful to include more information from Children Protective Services investigations.
- 2) While reviewers stated that services were sufficient, in a few cases they also mentioned specific issues they might have addressed in greater depth or other evaluation techniques that might be utilized. Among the observations: further evaluation of mood and anxiety disorders; in some cases, focusing more on psychopharmacological treatment issues and the use of specific types of psychological tests (such as projective and

personality tests and ones with validity scales) to augment an evaluation. In one report the reviewer felt that while the evaluation was comprehensive, it did not specifically address the referral question.

3) Other suggestions for improved services included a staffing with the treatment provider and more aggressive coordination of care.

4) Feedback was also given regarding how recommendations could be more focused, though it was found that recommendations are generally of excellent quality and adequately address the needs of children. The reviewers also offered suggestions for additional recommendations that might have enhanced the care plan. In two instances, the reviewers stated that they would have included recommendations regarding treatment options for parents.

### **TennCare & Dept of Education School Based Services Program**

CMS approved and TennCare and the Department of Education (DOE) are working together to implement the school-based direct medical services program that allows Local Education Agencies (LEAs) to bill Medicaid for medical services provided to Medicaid eligible children if the service is included in the child's Individualized Education Plan (IEP). These services are required to be provided under IDEA to allow the child to receive an appropriate education. This program will allow TennCare to draw federal funds to partially reimburse LEAs for the costs of these services. Direct Medical Services is a partner program to Medicaid Administrative Claiming (MAC).

LEAs are required to maintain a copy of the IEP and any additional doctor's orders for services billed to TennCare. LEAs will be provided a web-based system to submit claims to TennCare. LEAs must sign a provider agreement with the Department of Education which allows for auditing and oversight of claims billed. TennCare and the Department of Education have entered into a similar contract with outlines each entity's responsibilities.

This summer the school districts will begin training on Medicaid claiming procedures.

### **Project TEACH**

Project TEACH began in January 1995 as a cooperative effort between the Tennessee Department of Health, the Tennessee Department of Education and TennCare. One of the goals of the program was to increase coordination of services for children with special health care needs. In order to achieve this goal, one public health nurse, based in the health department, was assigned to each rural region of the state. These nurses then worked with school staff to identify children who were receiving medically necessary physical therapy, occupational therapy, and speech therapy during the school day. Initial surveys were done in each school that participated. It was found that many children were receiving care from more than one therapy

provider. The nurses then worked with parents, school system staff, primary care providers, and TennCare Managed Care Organizations to provide appropriate services. Providers who are identified by the appropriate managed care organizations deliver all medically necessary services in an effort to reduce duplication.

Types of other activities provided include home visits, referrals to BHOs for mental health services, assistance to MCOs in locating appropriate providers in rural counties, attendance at IEP meetings to assure that medical care is appropriate and to act as liaison for the family/guardian, referrals for EPSDT screens, and referrals to other programs/agencies. If there is difficulty in getting approvals for appropriate care through the managed care organizations, staff assist the families in navigating the appeals process. Since the programs inception these nurses have expanded into 40 of 138 school systems. Staffing limitation is the only thing that has curtailed the expansion.

### **Implementation Team**

The Implementation Team (IT) has continued its work of providing consultation in situations where TennCare children are at risk of entering state custody if they do not receive appropriate mental or behavioral health services.

The Implementation Team continues to participate in informal interdepartmental meetings. In addition, the IT participates regularly in an interdepartmental EPSDT task force meeting, Adolescent Health Team meetings, and the Tennessee Academy of American Pediatrics/TennCare meetings. IT has also participated in joint COE/Health Unit IT retreat; Tennessee Commission on Children and Youth (TCCY)Children's caucus, and the annual Tennessee Voices for Children Policy makers Meeting.

Between January 1, 2004 and June 30, 2004, the Implementation Team has had a total of 216 referrals. There are presently 28 active cases.

The referrals break down by DCS regions as follows: (Note that the IT may get more than one referral on a child because they live on boundary between regions or may have involvement with 2 different court systems).

Davidson: 25  
Mid-Cumberland: 25  
Upper-Cumberland: 9  
South Central: 22  
Hamilton: 22  
Knox: 16  
Shelby: 16  
Northwest:22  
Southwest: 9  
Southeast:4  
Northeast: 9  
East Tn.: 40

Six children were in custody at the time of referral. Fourteen children entered custody after referral. Seven of these children entered custody due to abuse or dependency/neglect issues and seven due to the Court's concern about community safety related to the child's criminal charge.

In this period, the letters of authorization were equally distributed over the three grand regions of the state.

The Implementation Team wrote the following letters of authorization: (note that some children had more than one authorization letter so total reflects numbers of letters and not number of different children)

- Six letters to the MCO for services on children with autistic spectrum and/or MR with behavioral problems
- One letter to BHO for residential for a child with Traumatic Brain Injury and behavioral issues.
- Twenty -two letters to BHO for residential treatment
- One for continuation of a residential wilderness program
- Two for intense in home Comprehensive Child and Family Treatment services
- Fourteen letters for continuation for MR/MH services either in home or therapeutic foster homes
- Twenty- one for new services for MR/MH through either in home or therapeutic foster homes

As in previous periods, the majority of dually diagnosed MR/MH children received services through Youth Villages CHOICES program.

## **Mental Health: Youth Villages Specialized Crisis Services for Children and Adolescents**

### **Update on Crisis Services:**

The Department of Mental Health and Developmental Disabilities (TDMHDD) continues to work in collaboration with AdvoCare of Tennessee and the Behavioral Health Organizations (BHOs) to monitor Youth Villages by several different methods. One method is by using their Youth Villages' Monthly Volume Reports. These reports include the following data for each region: number of calls received, number of face to face encounters, average time spent in face to face encounters, location of the encounter, average Youth Villages' response time, and patient disposition. Additionally, Youth Villages collects a second level of data using the referral source survey. This opinion survey about Youth Villages' performance is collected on a monthly basis from mental health workers, medical personnel, community members, law enforcement/juvenile personnel, school personnel, DCS staff, and others. Also, AdvoCare conducts chart and site audits of Youth Villages program and this information is monitored by TDMHDD. TDMHDD in conjunction with AdvoCare has conducted random crisis chart audits as

well. Although AdvoCare remains the lead on monitoring reports, the TDMHDD Office of Managed Care also reviews reports, discusses any concerns and makes suggestions for changes/improvements as needed with both AdvoCare and Youth Villages.

TDMHDD also has regular ongoing meetings with AdvoCare and Youth Villages to review reports of problems. This includes continuing to monitor any external complaints that are presented to AdvoCare or TDMHDD. AdvoCare does and will continue to conduct a thorough investigation of each Grievance appeal as well as all inquiries to assure that all appeals and inquiries are resolved in a timely manner. TDMHDD monitors AdvoCare's investigation of external quality concerns by conducting random investigations. This plan will better oversee and assure that Youth Villages is delivering timely and high quality services.

## **Part III: Coordination Paragraphs 78-83**

### **Mathematica**

In February, the state entered into a new contract with Mathematica Policy Research (MPR). This contract, which was to cover the period through January 31, 2005, is for \$155,804. Dr. Henry Ireys is the Project Director at MPR.

In the contract, MPR agreed to provide the following:

- Consultation on the development and implementation of action plans by the EPSDT workgroups which were established in response to a recommendation that MPR had made in its assessment completed in December;
- Consolidation of the action plans into a coordinated statewide strategy;
- Development of a management tool to track and report on progress of the workgroups;
- Identification of experts to provide strategic guidance and assistance to the workgroups;
- Development of a written action plan encompassing intermediate objectives and final goals for each workgroup, as well as meaningful short-term and long-term measurement strategies; and
- Production of a written management tool to provide a framework for the state to monitor and report on its progress on the overall action plan.

This contract was amended in the spring of 2004 to add an additional task: the development of a plan for enhancing screening percentages, which had been requested by the Special Master. The amount of the amended contract was \$179,595.

On April 29, 2004, MPR produced a document entitled “The EPSDT Program in Tennessee: Strategies for Enhancing Screening Percentages.” Projections of when Tennessee would reach an APSP of 80% and a DSP of 80% were made, based on three different scenarios. Estimates of when the desired screening percentages would be reached ranged from 2007 to 2010 for the APSP and from 2011 to well beyond 2013 for the DSP. This report was subsequently delivered to the Special Master. **(See Attachment B)**

In the early summer of 2004, MPR developed drafts of action plans for the various workgroups. On June 18, 2004, MPR submitted a document entitled “Improving the Performance of TENNderCARE: An Action Plan for Five Workgroups.” Because not all of the workgroups were fully operational at that time, it was decided to use MPR’s action plan as a device for assisting the workgroups in developing their own formal work plans, rather than as a final action plan in and of itself.

## **Governor's Office of Children's Care Coordination**

Services to children in Tennessee are delivered through multiple departments of state government. Each of these state departments has, as its principal focus, the delivery of services specific to that department and each maintains its own separate data system not integrated with those of other child-serving departments. As a result, the coordination and management of services from complex delivery systems involving multiple departments is a difficult challenge.

The extent of the challenge of providing such a system of coordinated care is exacerbated by the demographic features of the under-21 population in Tennessee, as reflected in the Kids Count 2003 Data Book produced by the Annie E. Casey Foundation. That study ranked states in overall child well being. Tennessee ranked 43rd out of 50, taking into account indicators such as the rate of teen deaths by accident, homicide and suicide; child death rates; percent of teens who are high school dropouts; percent of teens not attending school and not working; percent of children in poverty; and infant mortality rates as well as low birth weight babies.

Approximately 600,000 individuals under the age of 21 are enrolled in the TennCare program. A county -by-county breakdown indicates that the number of these enrollees ranges from a high in Shelby County of approximately 132,000 to a low in Moore County of approximately 398. Most counties have under-21 TennCare enrollee populations in the range of several thousand.

The State has taken decisive action to address the challenge of improving the coordination of the delivery of services to children. A major new initiative was begun during the period covered by this report: the establishment of the Governor's Office of Children's Care Coordination. On June 24, 2004, the Governor announced the creation of this Office and the appointment of Manny Martins as Director. Mr. Martins has served in a variety of health care related capacities both inside and outside of state government during his 30-year career, most recently as Director of the TennCare Bureau, and brings a wealth of relevant and critical knowledge to this position. The Governor's Office of Children's Care Coordination will operate out of the Governor's office. Its initial focus will be on the delivery of effective, efficient and coordinated health care services to children.

Governor's Office of Children's Care Coordination will play a key role in the state's ongoing activities to comply with the *John B. Consent Decree*, with the responsibility to ensure that the issues identified by the state, plaintiffs' counsel, and advocates are appropriately addressed by the various state departments involved in the delivery of EPSDT services. Among the Office's responsibilities is the development of a regional and community structure for a coordinated delivery network for services to children, to assure the provision of EPSDT services. The Governor's Office of Children's Care Coordination will also work to develop methodology and measures for evaluation of health outcomes for TennCare-enrolled children, including the

evaluation of network adequacy and the identification of service gaps in the state's delivery system. In addition, the Office is taking the lead in reviewing the different data systems within child-serving departments and developing solutions that will enable child-specific data to be collected across departments and integrated into a single children's services data information system, thereby improving coordination of care. The Office will also incorporate a mechanism to manage crisis referrals of children who are at risk of entering state custody because of an unmet need for health care services.

## **Governor's Workgroups**

The Governor's office has been working to assemble five workgroups that are designed to assist the state in improving the performance of TENNderCare. These workgroups are implementing specific action steps related to overall program goals and developing recommendations for additional program improvements. The activities of these workgroups build on and contribute to ongoing activities of state staff.

The Governor's EPSDT coordinating committee continues to meet regularly to facilitate the ongoing coordination and integration of EPSDT services as set out in paragraph 83 of the Consent Decree. The Commissioners hear reports of the Governors' EPSDT work groups and provide input and oversight for the work group activities.

### **Outreach Work Group**

To create broad awareness of the availability of the EPSDT program, the services it provides and the importance of preventive health screening for people under age 21 years of age the Governor's office has created the EPSDT outreach work group. The Work Group includes representatives from TennCare, the Department of Health, Department of Human Services, Department of Education and the Governor's office. The group is developing an integrated outreach campaign to raise awareness of EPSDT services among enrollees and providers. The Work Group is currently developing a comprehensive outreach campaign that will tie together the multiple EPSDT-related outreach activities currently conducted by various state departments and managed care organizations. The Work Group plan will also integrate with an EPSDT outreach plan that has been developed by the Department of Health at the Bureau's request.

As part of this process, the Work Group has met with various stakeholders, including advocates, to develop a new campaign theme and logo that will be used to brand all EPSDT outreach efforts. In addition the Work Group has inventoried existing outreach efforts currently being conducted by the MCOs, identified collateral materials that will be needed in the campaign, and created an initial media plan for a paid media effort.



In the coming months, the Work Group will complete the development of the campaign plan and accompanying paid media plan, and will develop collateral materials needed to support the campaign. The Group will also conduct EPSDT training sessions for state departments and external stakeholder groups in anticipation of a late-summer launch of the outreach campaign.

In addition to the outreach campaign, representatives from the TennCare Bureau have developed an initial outline and timeline for a training program that will provide a consistent introduction and overview of EPSDT services. This training effort will target employees of those state departments which are involved in the administration of EPSDT services and external organizations which provide EPSDT-related services (MCOs, for example).

The planned training approach will be a “train the trainer” model, where TennCare officials will train representatives from each state department and external stakeholder organizations on various facets of EPSDT using a standard library of training materials. These standard materials will be used by TennCare officials and the trained representatives from each organization to facilitate training of larger groups of individuals within each company or department. Implementing a standardized training module will provide consistent guidance on EPSDT requirements and protocols and ensure accurate information is being disseminated. Each training session will conclude with an evaluation component that will assess the participant’s knowledge of EPSDT-related programs. The Bureau will use this information to determine where additional training may be required.

These training sessions will be complete prior to the launch of the EPSDT outreach campaign which is being developed by the Outreach Work Group.

## **Part IV: Coordination and Delivery of Services to Children in State Custody Paragraphs 84-93**

### **Coordination and Delivery of EPSDT Services to Children in State custody**

#### **Access and Advocacy**

Children in the care of DCS receiving TennCare benefits access those services through the assigned MCO, TennCare Select, and through the BHO, managed by Advocare. DCS meets routinely (*a minimum of once a month effective March 2004*) with TennCare Select, as well as Advocare, to coordinate issues around service delivery. Network sufficiency, data needs, and work- flow process are customary topics. An example of follow up action as a result of the regular meetings is that designated staff of TennCare Select was added to the state GroupWise email to facilitate communications and data exchange.

Case managers continue to be educated regarding effective advocacy in accessing TennCare services, and this effort is reinforced by the use of “TennCare Tips,” which are published to DCS All via email. TennCare Tips have been published routinely (*on a weekly basis*) effective March 2004. In addition, the DCS intranet-based “Frequently Asked Questions” site for TennCare Services was updated in March 2004, and advertised to all DCS staff. This easy to access tool is an electronic handbook that provides the basics about TennCare in an easy to read format.

Regional Health Advocacy Units (“Health Units”) serve as a resource to assist case managers and others in DCS to advocate for and understand the TennCare service delivery assistance. Health Units file appeals when TennCare services are denied, delayed, reduced, suspended or terminated. Make referrals to the Implementation Team and the COEs for technical assistance and assessments, as well as guidance in the development of treatment plans.

Effective March 2004, DCS central office now receives a copy of any denied TennCare service for a child in care directly from the MCO and BHO, so that appeals may be filed regarding the denied service.

DCS has met with the TennCare Office of Contract Development and Compliance (OCDC) regarding appeals determinations and directives. DCS Commissioner Viola Miller met with Bureau of TennCare Director Manny Martins in May 04 regarding appeals directed to DCS for clarification on service delivery and documentation.

The State entered into an Agreed Protective Order with the Plaintiffs to facilitate the sharing of confidential information to the advocacy contractor and legal advocates representing children in DCS custody on TennCare appeals. This agreement was implemented in February 2004 and has facilitated advocacy when advocates request confidential medical and

behavioral records in order to provide advocacy to children in DCS custody pertaining to TennCare covered services.

### **EPSDT services are incorporated into Permanency Planning**

As reported in the last semi-annual report, DCS implemented changes to its Permanency Plan that prompts case managers to include the results of the latest EPSDT screening in the Permanency Plan. The Permanency Plan, now completed “on-line” in the child welfare tracking system, TNKids, is “pre-populated” with the results of the EPSDT screening if that data is available in TNKids. Training continued throughout the spring on the new Permanency Planning format. As indicated in the section of this report entitled

“Department of Children’s Services EPSDT Update: New Tracking application captures EPSDT Follow-Up Services” DCS has implemented effective April 30, 2004 a web based tracking application which tracks those services determined for the child as a result of a child and family team meeting. These services often include TennCare services. The identified services are entered following the child and family team meeting. The application enables DCS to track identified services, as well as the appointment date and the completion date of the service.

TennCare provides Centers of Excellence for Children in and at risk of custody. The Bureau of TennCare renewed its contracts with COEs to provide support for complex service delivery for children in and at risk of DCS custody. DCS Commissioner Viola Miller sponsored a planning retreat for COEs, Health Units, and the Implementation Team in May 2004, charging the group to define goals and begin to develop strategies to address the needs of this population. This planning process continues and will further inform the contract process.

DCS case managers and Health Units received training from Centers of Excellence during the past fiscal year regarding the following topics: Disruptive Behavior Disorders, Child Sexual Behavior, Psychiatric Medication, ADHD, Bipolar disorders, Autism, and Attachment Disorder.

Continuum contractors provide DCS-administered TennCare behavioral residential services. A workgroup of providers and DCS developed a re-design of the Continuum program that is currently being reviewed by the technical assistance committee to Brian A. DCS is using reporting data for contracting decisions and has contracted with an outside vendor to assist in the development of a comprehensive outcome-based performance contract model. Workgroups met on a regular basis in November and December '03, with enhanced focus on the Child and Family Team meeting process and how it informs the Continuum Service delivery system, as well as requirements for in-home services in the continuum model. DCS providers have participated with the department in various capacities to review outcomes-based data, including in a conference call with Commissioner Miller. DCS has developed outcome- based measures to be included for the '05 FY for residential contract agencies.

Another goal regarding DCS TennCare administered behavioral residential services was that DCS would develop documentation guidelines for DCS providers in cooperation with TDMHDD. DCS has completed the guidelines, with input from DMHDD, and DCS held regional training events in March for contract agencies. Three trainings for each Grand division of the state were held and the guidelines were reviewed. In addition, DCS is including the guidelines in the fiscal year '05 contract policy manual, and training on the guidelines will be incorporated into the standards training cycle for providers so that it is on-going.

#### **Provider Network Adequacy**

The Geo-access standard for DCS TennCare administered residential behavioral services is 75 miles from the child's county of entry into care. DCS routinely measures placements within 75 miles of the child's entry for children in care, and regional administrators must authorize, or "waive" placement outside the requirement.

DCS tracks appeals filed and directives issued that relate to the DCS administered TennCare services, and provide data to the central office and field staff. Each month since February 2004, Regional administrators have received a summary of the directives issued to DCS. Commissioner Miller reviews this data in conference calls with Regional Administrators.

The Health Advocacy division provides to the central office resource division notice of all appeals and directives, to inform the division regarding Provider Network sufficiency.

#### **Protection from Harm**

Policies on psychotropic medication were adopted April 04 and have been published. The department is currently developing a comprehensive training program related to psychotropic medications and behavioral management strategies. DCS is contracting with a child psychiatrist to lead the development of the training. The department will also collaborate with the newly developed "training consortium" of Tennessee Universities.

## **Part V: Monitoring and Enforcement of MCO and DCS Compliance Paragraphs 94-103**

### **TennCare**

#### **MCO Contract Update for John B. Semi-Annual Report:**

General Amendment 5 was executed between the MCOs and TennCare with an effective date of July 1, 2004. The Amendment contains several items which strengthen and clarify EPSDT provisions as well as encourage an increase in screening percentages.

These changes are as follows:

- 2-3.u was amended by adding a requirement to utilize the new TENNderCARE logo when referring to EPSDT services. The amended language reads as follows:  
"The State EPSDT program shall be referred to as "TENNderCARE". The CONTRACTOR shall use "TENNderCARE" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENNderCARE as of July 1, 2004."
- Section 2-3.u.7(a)1. was amended to clarify acceptable forms of notification to enrollees as follows:  
"Information included in the member handbook regarding EPSDT services must be sent within thirty (30) days of receipt of notification of enrollment as specified in Section 2-5.b.1 and 2-6.b.1. Annually thereafter, upon the Enrollee's anniversary date of enrollment, the CONTRACTOR shall send an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services. All handbooks must be in accordance with the TennCare Marketing Guidelines and Section 2-5 of this Agreement."
- Section 3-10.h.3(a) was added in order to provide incentive for MCOs to achieve higher screening percentages 3-10.h.3(a) Variable Administrative Fee Payment for Fiscal Year 2005 The CONTRACTOR agrees Section 3-10.h.3(a) shall be applicable for the period October 1, 2004 through September 30, 2005 only. In addition to the fixed administrative fee specified in Section 3-10.h, the CONTRACTOR shall have an opportunity to earn a variable administrative fee payment subject to the availability of funds.  
The variable administrative fee will not differ by eligibility category. The amount that is actually paid out to an individual MCO will vary based on the MCO's level of performance. The CONTRACTOR must meet the criteria for payment and obtain or exceed the level of performance for the performance measure specified in the table below

to be eligible for the pay-out of the portion of the variable administrative fee allocated to that measure. Unless an alternative pay-out schedule is mutually agreed to by TENNCARE and the CONTRACTOR, TENNCARE will measure the CONTRACTOR's performance within one hundred eighty (180) calendar days of the end of the federal fiscal year and payouts shall be made, subject to the availability of funds, within thirty (30) calendar days thereafter. The CONTRACTOR shall be responsible for maintaining data to validate increased EPSDT Complete Medical Screening Rates. Data may be reviewed and audited by TENNCARE.

| <b>PERFORMANCE MEASURE</b>                   | <b>MEASUREMENT</b>  | <b>BENCHMARK</b>   | <b>PAY-OUT FORMULA</b>   | <b>DATA SOURCE</b>   |
|--|---|--|--|--|
| <b>EPSDT Complete Medical Screening Rate</b> | EPSDT complete medical screening rate shall be calculated by multiplying the EPSDT screening ratio, calculated in accordance with specifications for the HCFA-416 report, by the percentage of the required seven (7) components that are completed as determined through the MCO's documentation | 80% of children under the age of 21 receive timely and complete EPSDT Medical screenings | <p>If EPSDT Complete Medical Screening Rate equal to or greater than 65% and less than 70%, Pay Out: .40 per child per month</p> <p>OR</p> <p>If EPSDT Complete Medical Screening Rate equal to or greater than 70% and less than 75%, Pay Out: .60 per child per month</p> <p>OR</p> <p>If EPSDT Complete Medical Screening Rate equal to or greater than 75% and less than 80%, Pay Out: .80 per child per month</p> <p>OR</p> <p>If EPSDT Complete Medical Screening Rate equal to or greater than 80%: 1.0 per child per month</p> | <p>EPSDT Screening Rate: MCO encounter data</p> <p>7 Components of a Screen: MCO data which may be audited by TENNCARE</p> |

## **TennCare Office of Contract Development and Compliance\Provider Services Unit**

### **Quarterly up-to-date List of Specialists**

Per Paragraph 62 of the John B. Consent Decree, each MCO is required to provide each primary care provider participating in the EPSDT program an up-to-date list of specialists to whom referrals may be made for screens, laboratory tests, further diagnostic services, and corrective treatment.

During this period all MCOs submitted proof of documentation to TennCare of the updated list of specialists along with proof of timely mailing.

### **Monitoring for Provider Networks Deficiencies**

The Provider Services Unit of TennCare issued thirty-four (34) EPSDT related provider network deficiency notices and requests for Correction Action Plans (CAPs) to six (6) MCCs. OCDC tracked and monitored receipt of thirty-four (34) CAPs for provider network deficiencies noted in various counties and specialties. The reports were received in a timely manner and were approved.

Additionally, Provider Services issued seventeen (17) provider enrollment file data correction notices and requests for CAPs to 8 MCCs. This request was based on telephone survey results of randomly selected PCP and Specialist provider types. OCDC tracked and monitored receipt of seventeen (17) CAPs for provider enrollment file data corrections identified in various specialty types. The reports were received in a timely manner and were approved.

### **EPSDT Directive Analysis**

An analysis of all directives issued by the TennCare Solutions Unit for this reporting period is provided in a series of graphs. **(See Figures 3.1, 3.2, 3.3, 3.4 and 3.5) pp 55-58.**

### **Liquidated Damages Assessed**

Per Paragraph 101 of the Revised John B. Consent Decree, TennCare will review appeals filed under the TennCare Program to determine whether deficiencies or repeated violations necessitate financial penalties upon managed care contractors and sister state agencies which have inappropriately denied EPSDT services to children.

Attached are liquidated damage assessments and rescissions that were executed for this reporting period. (Attachment C)

TennCare may assess a MCO a liquidated damage sanction for failure to provide a service/reimbursement timely or accurately.

Following the assessment of a sanction, if a MCO submits additional documentation to clarify an issue in a directive, TennCare will review that information. At the discretion of TennCare the sanction may be rescinded either fully or partially depending upon the circumstances. The attached report reveals rescission activity for this reporting period. (Attachment C)

### **Mental Health:**

TDMHDD/Office of the Medical Director (OMD) utilized the semiannual monitoring process to review randomly selected mental health records of children and youth regarding the mental health services children are prescribed and those services actually received. Data collection on Level 3 DCS providers was completed during the second quarter (April-June) of 2004. Analysis includes a review of mental health services prescribed and services received by those children in the sample who were in DCS custody at that time. A review of DCS mental health policies and procedures was completed and feedback provided in the first quarter (January-March) 2004. The conclusions from the second quarter (April-June) 2004 report are as follows:

#### **Observations**

- There is a high incidence of mental health diagnosis/ identification as priority population within the Level III placement population
- There is a high rate of service provision
- Children who are prescribed medications are often prescribed multiple medications

#### **Findings related to the "Best Practice Guidelines":**

- Consumers are getting the newer medications to treat their respective illnesses

TDMHDD/Office of the Medical Director (OMD) utilized the semiannual monitoring process to review randomly selected mental health records of children and youth regarding the mental health services children are prescribed and those services actually received. Data collection on Level 3 DCS providers was completed during the second quarter (April-June) of 2004. Analysis includes a review of mental health services prescribed and services received by those children in the sample who were in DCS custody at that time. A review of DCS mental health policies and procedures was completed and feedback provided in the first quarter (January-March) 2004. The conclusions from the second quarter (April-June) 2004 report are included below. OMDs Report is forwarded to OMC, who addresses any areas of concern or findings needing additional attention with DCS in their bi-weekly meetings and requests a corrective action plan if necessary.



**Mental Health Contracts:**

There were no BHO contract amendments developed by TDMHDD/Office of Managed Care (OMC) during the reporting period of January 1, 2004 through June 30, 2004 that effected enrollees under the age of 21.

**Update on Nashville Connection System of Care Grant**

The Tennessee Department of Mental Health and Mental Retardation received a grant October 1, 1999 from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). The federal program is authorized in Section 561 of the Public Health Service Act and is entitled the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program. The Tennessee grant, entitled the Nashville Connection, is in the amount of \$7.25 million federal dollars and \$5.9 million state match dollars for a five year period.

In 2001, Congress extended the grant period from five to six years with the match remaining the same as for year five, i.e., \$2 state dollars for each \$1 federal dollar. The TDMHDD reapplied for a sixth year under the grant and was awarded \$510,000. The \$1,020,000 state match for year six consists of \$620,000 cash & in-kind (TDMHDD), \$100,000 cash (TDOE), \$300,000 (in-kind DCS).

Contracts for FY 2005, year six of the federal grant, remained with the current vendors: Tennessee Voices for Children for Family Advocacy and Support; Centerstone, Inc. for teacher education and support; Vanderbilt University Institute for Public Policy Studies, Center for Child and Family Studies.

**Pertinent Findings**

|  |
|--|
| Number of children & families ever served October 2000 to July 19, 2004:<br>261            |
| Number of children with 2 diagnoses (10-16-2000 to 6-30-2003):<br>44%                      |
| Of 203 children with GAF scores, 184 had a score below 50; 107 had a score of 43 or below. |
| Number of families participating in the national evaluation<br>65%                         |
| Enrollment as of June 30, 2004:<br>138   |
| Enrolled children (6/30/2004) remaining in the community:<br>132                           |
| Number of schools being served as of 6/30/04:<br>52  |
| Number of teachers receiving project services (same as last report)<br>390                 |

|  |      |         |
|--|------|---------|
| Estimated number of students benefiting indirectly from teacher support and education [same as last report]<br>54,000                      |      |         |
| Average Rating of 10 items on a 4 point scale with 4 being the best:<br>3.73   |      |         |
| Range of Scores  | 3.40 | to 3.84 |
| Highest Score: "Supports my efforts to teach and manage specific children in my classroom"<br>3.84   |      |         |
| Lowest Score: "How important do you feel it is to expand the MHL program to children who do not have a formal designation of SED?"<br>3.40 |      |         |

The next full report on Nashville Connection performance measures will be available in August 2004. Outcomes included in an interim evaluation report (VIPPS, February 2004) are as follows:

- Caregiver Reported Changes in School Attendance Over Time: 75% decrease in school absenteeism
- School Discipline Report by Caregiver and CAFAS: School Functioning:
  - At baseline 83% of the children had experienced school suspension; at 6 months 56% had experienced suspension, a 33% decrease.
  - Baseline to 12 months showed a 27% decrease in school suspensions
  - At baseline 6% of the children had experienced school expulsions. At 12 months there were 0 school expulsions.
- The Child and Adolescence Functionality Scale (CAFAS) School Role Chart shows a drop from an aggregate score of 28.5 at baseline to just under 25.5 at 12 months. (Higher CAFAS scores indicate more functional impairment.)
- Caregiver report on cooperation among their child's service providers went from approximately 59% at six months to approximately 79% at 12 months.
- 93% of caregivers said they wanted to continue with Child and Family Team meetings at 6 and at 12 months.
- Episodes of Residential Care: Children with 12 Month Data (VIPPS Patterns of Change, November 2003). Children enrolled in Nashville
- Connection experienced a 37% drop in episodes of residential care from baseline to 12 months.

In addition to the work of the demonstration site, the State System of Care Council under the grant formed a subcommittee to discuss how to improve the service system to meet the needs of youth in transition from child to

adult services. A position paper was finalized in April 2004 and has been submitted for review by participant agency heads. The group's goal is to bring the needs of these youth to the attention of the Children's Cabinet Council for interagency planning, service delivery, and monitoring.

### **Monitoring of the BHOs' delivery of services to children**

The Research and Evaluation (R & E) unit of the Office of Managed Care (OMC) regularly monitors the BHOs' service delivery through several mechanisms. In June 2004, the R & E unit, Office of Managed Care became solely responsible for reviewing the BHOs' monthly case management reports, and has taken the lead in monitoring this standard. Additionally, R & E conducts a report in regard to the services provided to children in DCS custody who are receiving services through the BHO. The most recent report was completed in November 2003. The R & E unit also reviews the BHOs' quarterly quality improvement reports, which contain data on their progress with contractual performance standards. The contractual performance standards reviewed by R & E in regard to children include provider network (geo-access standards), outpatient appointment timeliness, case management, ambulatory follow-up after discharge from inpatient or residential treatment, and inpatient readmission rates. Each quarter OMC staff meets with the BHO staff to discuss any issues regarding their compliance with these standards and work with the BHO to improve any areas of deficiency. In April 2004, R & E completed a review of the BHO's 4th quarter quality improvement report.

### **Monitoring Access to Services:**

The Department of Mental Health and Developmental Disabilities (TDMHDD) in conjunction with AdvoCare of Tennessee, the Behavioral Health Organization (BHO) has reviewed/implemented proposals from providers state- wide for the purpose of expanding and enhancing children's services. Approval/denial letters were sent to providers in December 2003. Expansion of services includes grants as follows:

Six telemedicine grants which include equipment and line usage for the primary objective of medication management for under served geographic areas of the state at the following CMHAs:

- 1) Frontier Health to cover- Unicoi and Hawkins Counties as well as Johnson City and Mountain City
- 2) Carey Counseling Center to cover- Henry, Gibson, Trenton, Obion, Carroll, Benton, Lake and Weakley Counties
- 3) Centerstone to expand their existing telemedicine services to also cover Hohenwald and Waynesboro. Existing telemedicine services currently cover- Stewart, Montgomery, Robertson, Sumner, Humphreys, Houston, Dickson,

Cheatham, Davidson, Hickman, Lewis, Maury, Lawrence, Wayne, Giles, Lincoln, Bedford, Coffee, and Franklin

4) Quinco to cover- Madison, Decatur, Hardeman, Hardin, McNairy and Henderson Counties

5) Cherokee to cover-TBA

6) Mental Health Coop- Davidson, Dickson, Sumner Counties

7) \*Volunteer was a late entry also receiving a telemedicine grant to cover - Wilson, Trousdale, Rutherford, Williamson, Cannon, Hamilton, Overton, counties

Nine grants for additional child psychiatrist/nurse practitioner time at the following CMHAs:

1) Frontier to cover-Johnson, Unicoi and Carter counties

2) Ridgeview to cover- Anderson, Roane, Morgan, Campbell and Scott counties

3) Centerstone to cover-TBA

4) Helen Ross McNabb to cover - Blount, Sevier and Knox Counties

5) Comprehensive Counseling Network to cover -Shelby County

6) Midtown Mental Health to cover -Shelby County

7) Professional Counseling Services to cover- Dyer, Madison, Lake, Obion, Weakley, and Gibson Counties

8) Quinco to cover- Madison, Decatur, Hardeman, Hardin, McNairy and Henderson Counties

9) Mental Health Coop to cover- Davidson, Dickson, Sumner Counties

Four grants for school based services at the following CMHAs:

1) Whitehaven Mental Health Center to cover -Shelby County

2) Frontier Health for 3 masters level clinicians to cover- Carter, Washington, Unicoi and Hawkins Counties

3) Volunteer to cover - Grundy, McMinn, Meigs, Bledsoe, Rhea, Hamilton, Polk, and Bradley Counties

4) Family Success Services to cover -Humphreys County

Three grants for MH services at primary care giver's office at the following CMHAs:

1) Professional Counseling Services, 4 Masters level clinicians at MD offices to cover – Tipton, Lauderdale, Dyer, Fayette, and Haywood Counties

2) Southeast Mental Health Center to cover - NP at MD's office in Shelby County

3) Comprehensive Counseling Network to cover -3 clinicians at MD office- Shelby County

Two grants for dual MH/A&D services at the following CMHAs:

1) Restoration Counseling to cover- McMinn, Meigs, Polk and Monroe Counties

2) Helen Ross McNabb to cover- Blount, Sevier and Knox Counties

One grant for A&D only services at the following CMHA:

- 1) Comprehensive Professional Services to cover- Shelby County

One grant for specialized OP (specific to physically/sexually abused children) at the following CMHA:

- 1) Volunteer to cover- Cleveland, Warren, Hamilton, Van Buren, Sumner, Wilson, Rhea, Marion, Cumberland, Overton, Pickett and Fentress Counties

One grant for girls group therapy at the following CMHA:

- 1) Ridgeview to cover -TBA

Two grants for added days of after hours intakes at the following CMHAs:

- 1) Whitehaven Mental Health Center to cover- Shelby County
- 2) Comprehensive Counseling Network to cover- Shelby County

One grant for a bilingual services at the following CMHA:

- 1) Frontier Health to cover – Unicoi and Hawkins Counties

TDMHDD also has regular ongoing meetings with AdvoCare and Youth Villages to review reports of problems. This includes continuing to monitor any external complaints that are presented to AdvoCare or TDMHDD. AdvoCare does and will continue to conduct a thorough investigation of each Grier appeal as well as all inquiries to assure that all appeals and inquiries are resolved in a timely manner. TDMHDD monitors AdvoCare's investigation of external quality concerns by conducting random investigations. This plan will better oversee and assure that Youth Villages is delivering timely and high quality services.

\*Grants cover some cities in the reported counties

## **TennCare Office of General Counsel**

The Office of General (OGC) is responsible for preparing medical service appeals for hearings before an Administrative Law Judge and litigating these appeals on behalf of the Bureau of TennCare. OGC also works in an advisory capacity with the TennCare Solutions Unit (TSU) and the TennCare Office of Contract Development and Compliance (OCDC). A large part of this collaboration is directed towards improving compliance with the requirements for EPSD&T, the *Grier* Revised Consent and the *Grier* Revised Consent Decree (Modified).

### **OGC- identified EPSDT Issues:**

During the period under review, OGC intensified its focus on notice requirements pursuant to the federal fair hearing regulations and the *Grier* Revised Consent Decrees. In the process, OGC assisted the MCC's in improving notice to enrollees of denials of EPSD&T services, and in resolving problems involving delivery of services to enrollees. OGC also assisted OCDC

in reviewing and drafting transportation policies for EPSD&T enrollees. The following issues were identified and addressed:

1. **BHO services for EPSDT enrollees:** OGC identified several compliance problems with the Behavioral Health Organizations (BHO's) denial letters for these behavioral health services to enrollees under twenty-one years of age. During the period under review, OGC, along with TSU and OCDC, devoted a significant amount of time and direct technical assistance to the BHO's with the objective of eliminating these compliance problems and giving appropriate denial notice to enrollees. The review process should result in a significant improvement in this area.

During the review period, OGC also participated in case review meetings with the BHO's. These meetings provide the groups involved with a forum for jointly and speedily resolving problems impeding the delivery of services to difficult and, or, complicated cases.

2. **Transportation services for EPSDT Enrollees:** OGC assisted and advised OCDC in drafting transportation policies for EPSD&T enrollees. It is expected that these policies will not only clarify for the Bureau, various issues on the provision of transportation, but also assist the MCC's in improving this area's compliance with EPSDT requirements.
3. **Quality Control:** OGC continued its review of its quality improvement process. Some improvements have been implemented and it is expected that further changes will be implemented during the second quarter of 2004, as staff resources become available. When fully implemented, the new process should improve the identification of systemic issues and ensure prompt referral of those issues to the Bureau of TennCare to determine whether program changes and, or, corrective action is necessary. The review process should also be more effective in identifying emerging issues and in prompting corrective action, thus reducing the number of issues that rise to the systemic level.

### **Summary of Reports:**

During the January to June period OGC received a total of 1,813 EPSD&T appeals. Of these appeals, 668 were for dental services, 280 were pharmacy, 326 were BHO, and the remaining 538 were appeals for medical services. Five hundred seventeen (507) EPSD&T appeals were closed during the reporting period. Ninety two (92) were closed by Administrative Law Judge (ALJ) rulings in favor of the enrollee, and 108 cases were closed because of informal resolutions, or by withdrawals by the enrollee. In many instances, appeals are withdrawn because the MCO or TennCare approved the service or offered an alternative which the enrollee accepted. One hundred and

sixty nine (169) appeals were dismissed by ALJ's because of enrollees' failure to appear for hearing after being duly notified.

## **TennCare Solutions Unit**

The TennCare Solutions Unit (TSU) is the medical appeal resolution unit for TennCare. TSU works closely with Schaller-Anderson of Tennessee, Inc. (SAT), the contractor responsible for performing all appeal related medical necessity evaluations and with internal units such as the Office of General Counsel and the Office of Contract Development and Compliance in carrying out its activities.

During the latter part of last year, the Bureau of TennCare developed and implemented a Preferred Drug List (PDL). The pharmacy carve-out and the PDL helped to reduce the overall number of EPSDT appeals from an average of over 2,000 per month to the current rate of less than 1,000 per month. During the first half of 2004, this trend continued downward as the total number of EPSDT appeals for the reporting period was 5,431 or approximately 905 appeals per month.

### **TSU-identified EPSDT Issues**

The following issues are the major EPSDT issues identified by the TSU during this six-month period.

1. **Dental:** The TSU continues to work closely with Doral Dental and the TennCare Dental Director to coordinate the resolution of all appeals. During the six months covered by this report, the predominant issues, for dental appeals, continue to be for orthodontia and for delays in service for children in state custody, the latter filed by advocates acting in behalf of the child. Dental appeals continued to decrease as well. During the prior period there were 737 dental appeals received and this period there were 594.
2. **TennCare Pharmacy Preferred Drug List (PDL):** Pharmacy appeals during the reporting period continued to experience a decrease and are no longer the most appealed for EPSDT service. Pharmacy appeals are primarily received for non-covered medications. During the six-month reporting period the total number of pharmacy appeals received dropped from 409 (2<sup>nd</sup> half 2003) to 202 (1<sup>st</sup> half 2004).
3. **Better coordination for children in state custody:** The TSU continues to strive to increase communication and strengthen the relationship between the TSU and the advocacy group for children in state custody. The advocates and the TSU conduct a weekly paper review of new appeals to ensure that all are being reviewed timely and completely. Additionally, the TSU now meets monthly (in-person) with the children's

advocacy group to discuss difficult cases and coordination functions. Appeals are filed predominantly by the advocates and case managers. During the reporting period TSU staff attended a joint training session with the advocates and DCS staff conducted by the latter. The purpose of the session was to educate all on the changes within DCS and to foster better communication between all entities. The TSU is also meeting

regularly with representatives of DCS to develop better response mechanisms for the appeals process. These meetings are also attended by OGC and OCDC.

4. **Better coordination for children requiring mental health services:** The TSU in conjunction with OGC and OCDC have also been meeting regularly with representatives of the Tennessee Department of Mental health and with representatives of the two BHO's. These twice monthly meetings are used to review both form and content of the appeal responses from the BHO. The TennCare staff have reviewed appeal response templates and BHO policies and procedures. The meetings have also been used to review difficult appeals to ensure a timely and appropriate response.
5. **Expedited vs. Non-Expedited Appeals:** Almost 60% of all appeals are filed as expedited appeals (57.7%). The remainder (43.3%) include pharmacy appeals. This trend is continuing to climb each reporting period.

### **Summary of Reports**

The Schaller-Anderson reports attached provide data on EPSDT related appeals activity during the first six months of 2004 and are specific to type of appeal, appeal totals per plan and in the aggregate.

#### **Figure 1.1: Overall EPSDT Appeals by Month**

Details the number of appeals in the aggregate for each of the 6 months. The number of appeals has continued to decrease during the six-month reporting period. There is an 11.5% decrease from the last reporting period (6,134 decreased to 5,431).

#### **Figure 1.2: EPSDT Area of Appeals**

Details the types of appeals by volume. Declines were evident in the areas of pharmacy, dental, medical services and DCS appeals. The most dramatic increase was seen in BHO appeals. This increase was the direct result of perceived delays in accessing initial care, requests for continuation of services scheduled for termination and denials of residential placements (164 appeals last period increased to 233 this period). MCO Change Appeals continue to be the largest area of appeals followed by reimbursement and billing appeals.



**Figure 1.3: EPSDT Appeals Resolution by Level**

Details the numbers of appeals resolved at each level of the appeals process during the six-month period. As this report includes appeals filed in the previous period which are resolved in this period, and excludes appeals filed in this quarter that

are still pending, the number of appeals resolved does not match the number received during the reporting period.

In excess of 88% of all appeals continue to be resolved in the TSU either by the MCC reversing its decision or by action taken by the TSU. Less than twelve percent of all appeals required transfer to the Office of General Counsel for an Administrative Law Judge hearing.

**Figure 1.4: EPSDT Appeals per 1000 TennCare Enrollees by MCO by Month**

Details the number of appeals by MCO plans per 1,000 enrollees for each of the six months. This report only includes the MCOs that are still active participants in TennCare.

**Figure 1.5: EPSDT Enrollment Percentages by MCO and Region**

Details the number of appeals by MCO and region of the state. TennCare Select, the only state-wide plan, received 37% of all appeals during the reporting period. The appeal percentages remained virtually unchanged from the last reporting period.

**Figure 1.6: EPSDT Comparative Appeal Timelines**

This report details the percentage of expedited vs. non-expedited appeals received during the reporting period. Approximately 58% of all appeals received are expedited.

**Figure 1.7: EPSDT Appeals per K by Month by Regions**

Details the numbers of appeals received by region. The total number of appeals decreased across all areas of the state.

Figure 1.1

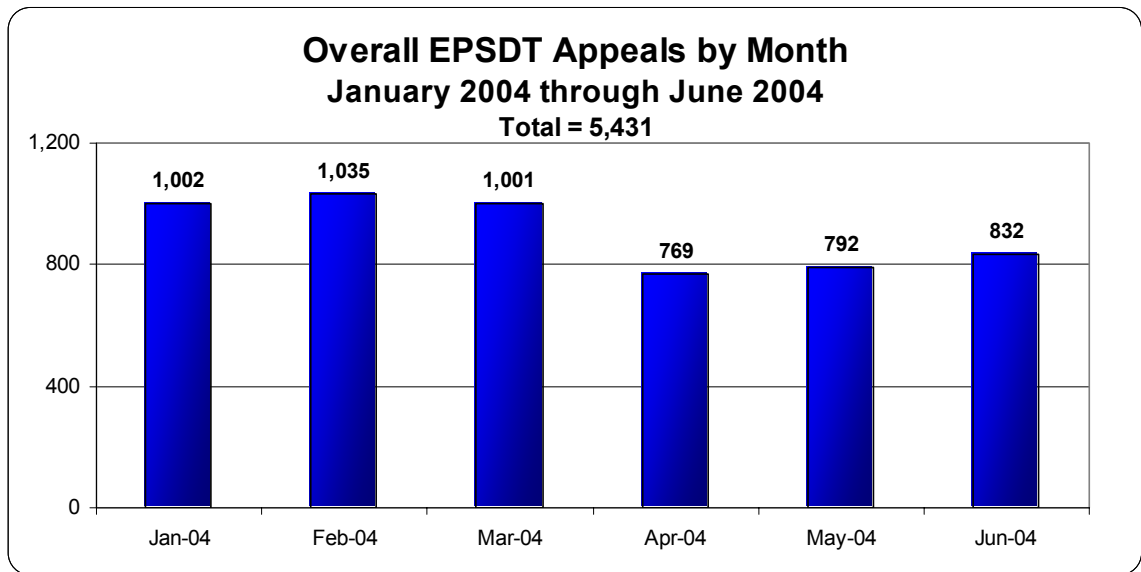


Figure 1.2

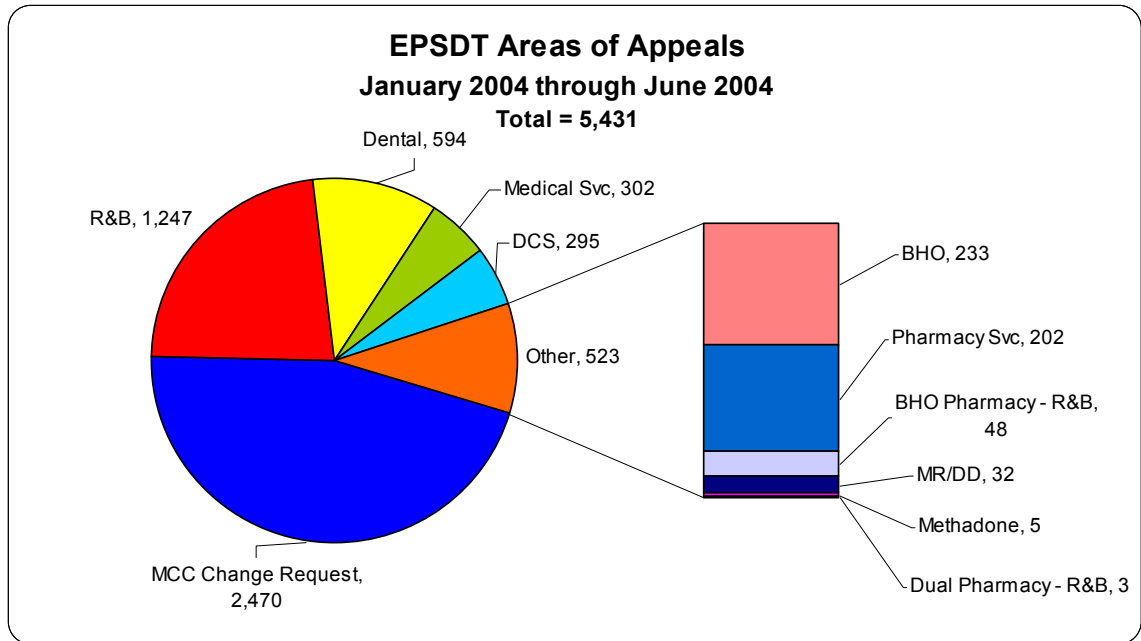


Figure 1.3

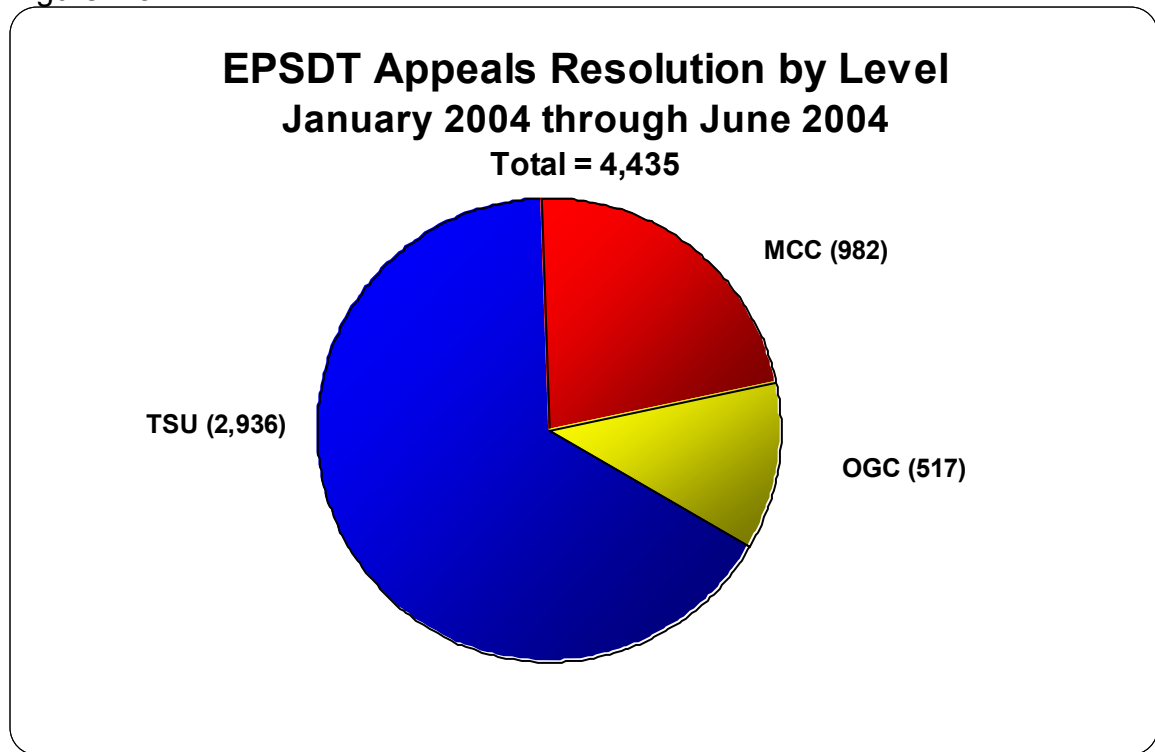


Figure 1.4

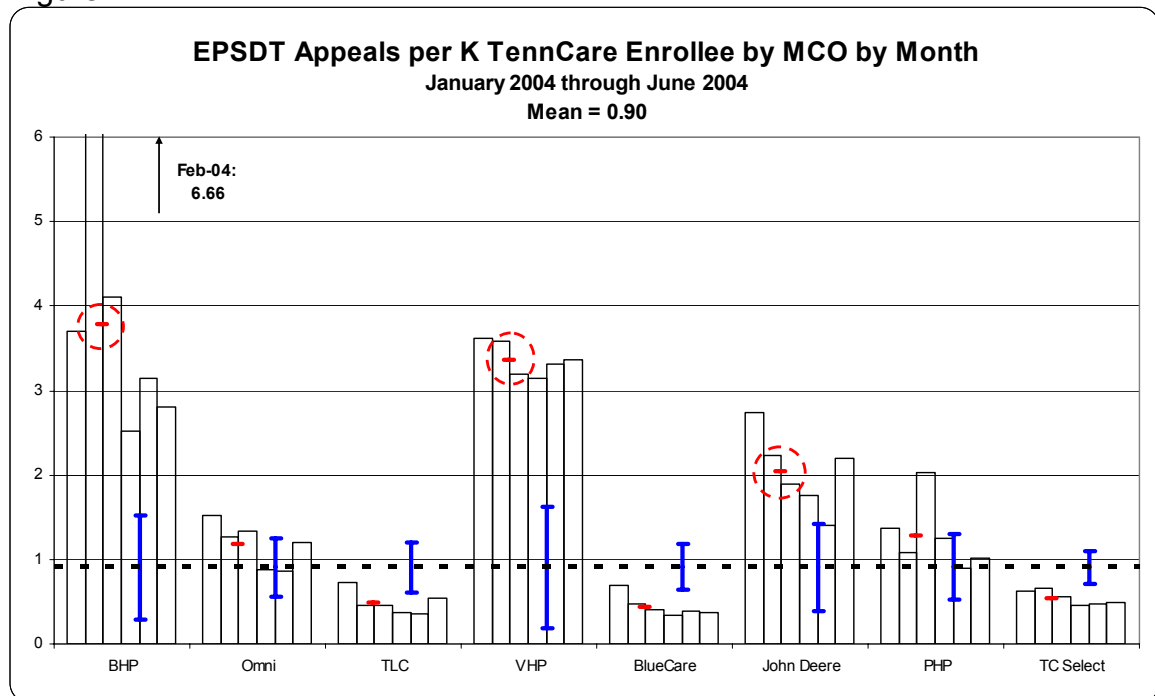


Figure 1.5

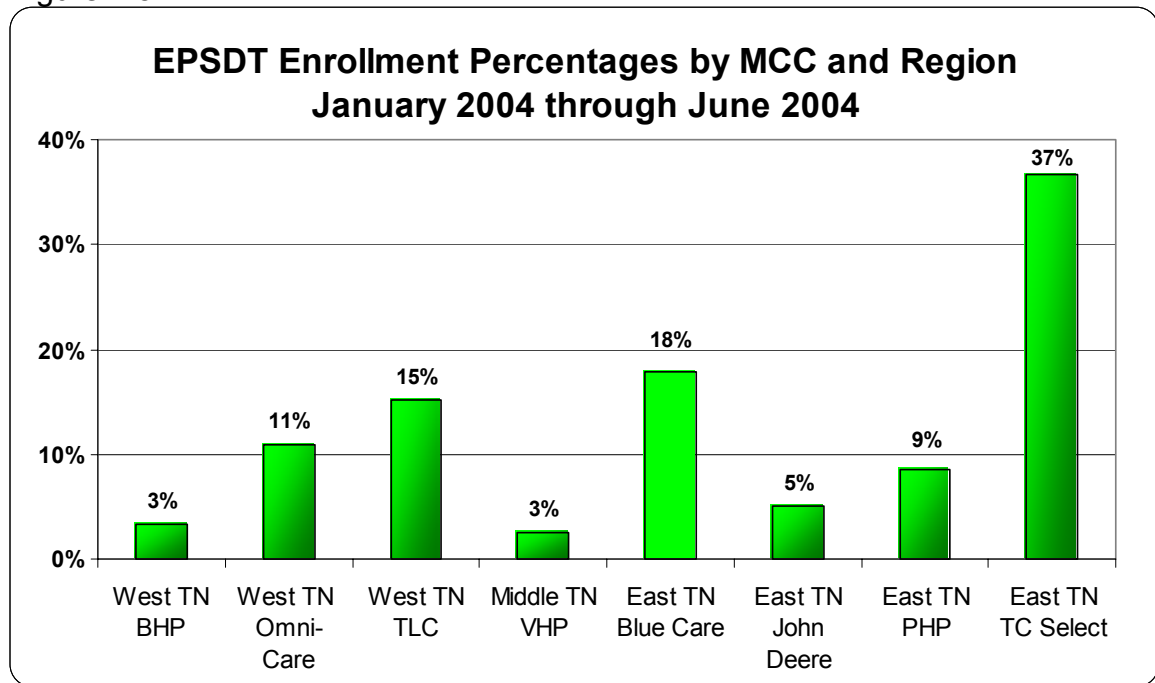


Figure 1.6

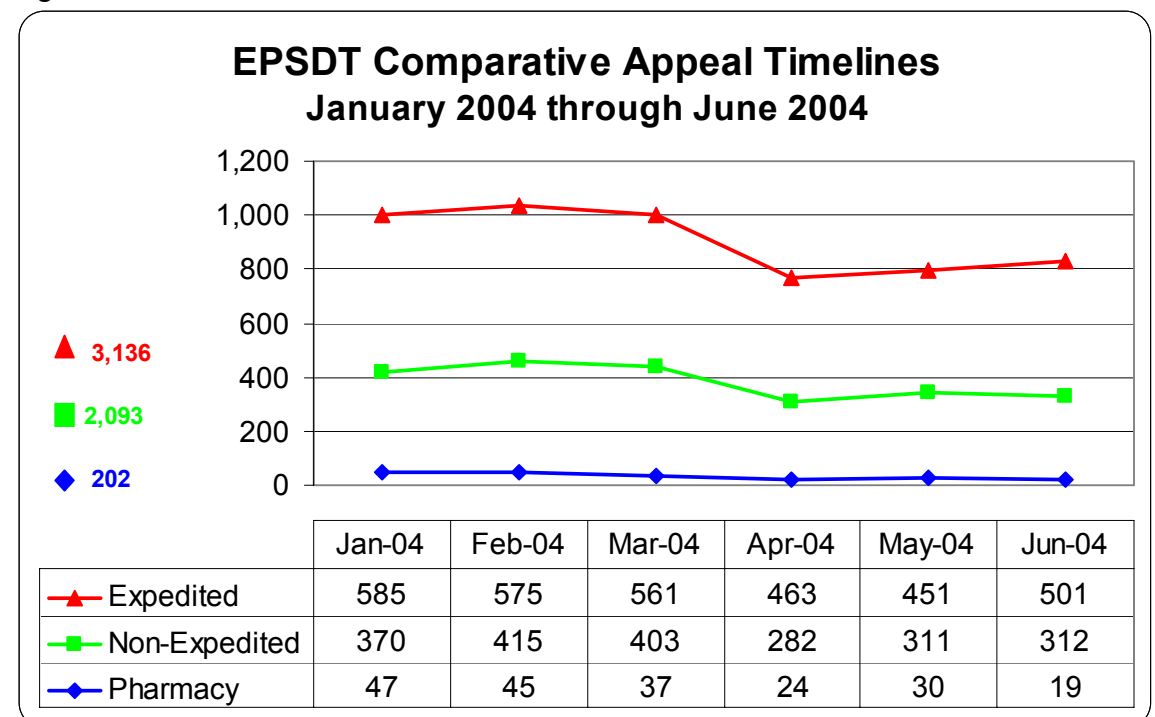
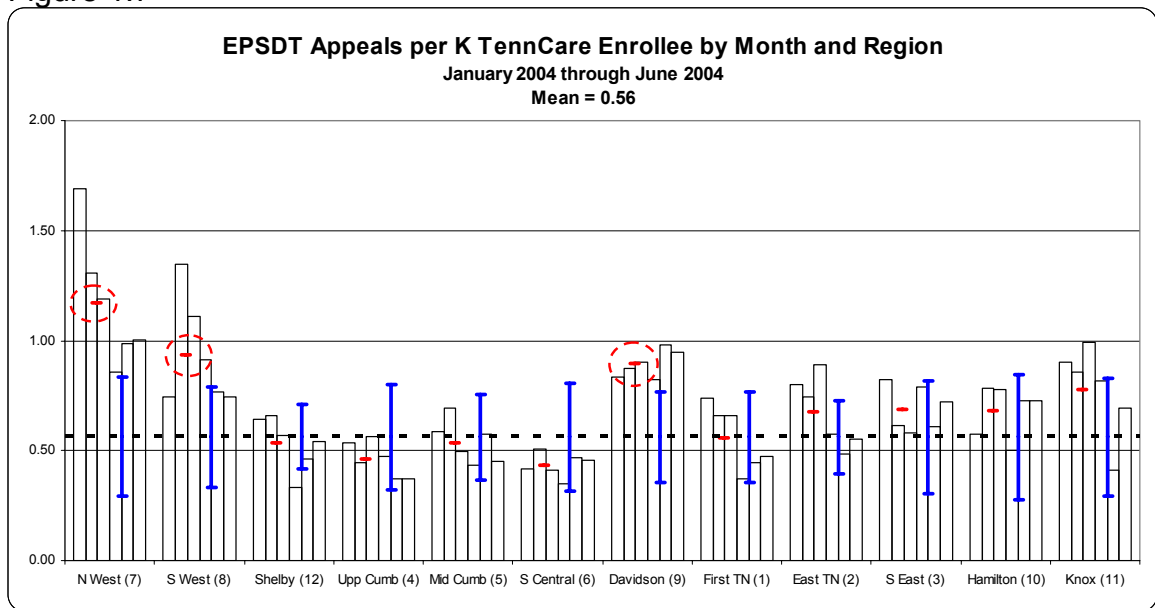


Figure 1.7



(07/19/04)

# OCDC

Figure 3.1

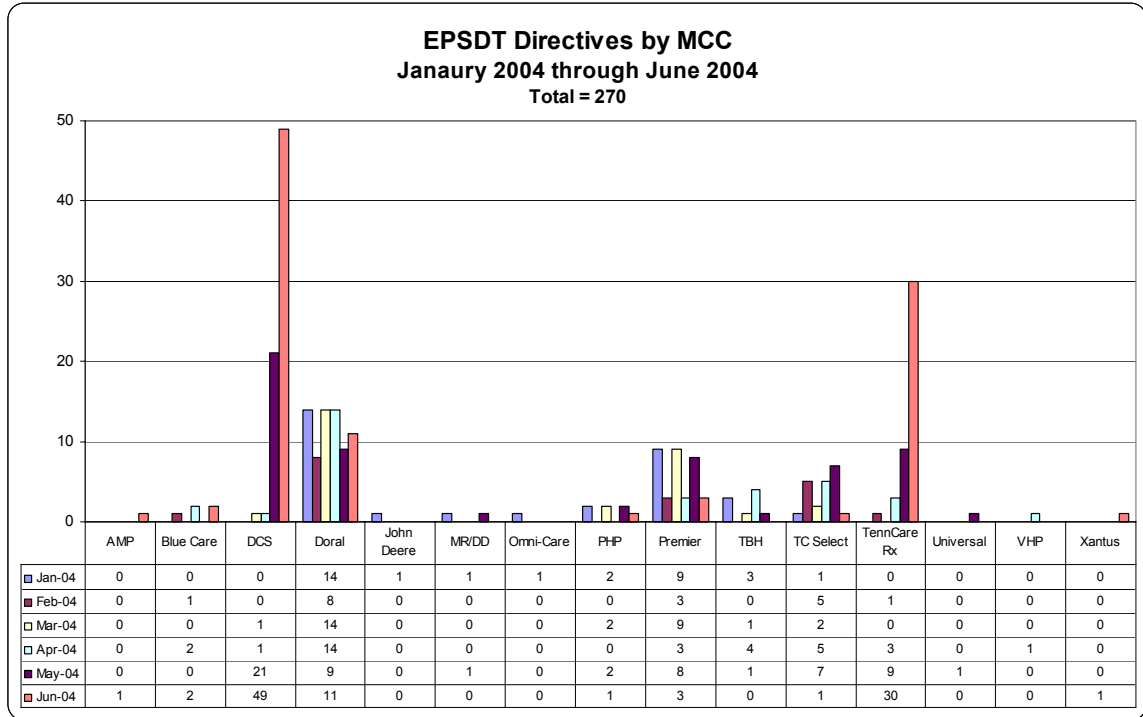


Figure 3.2

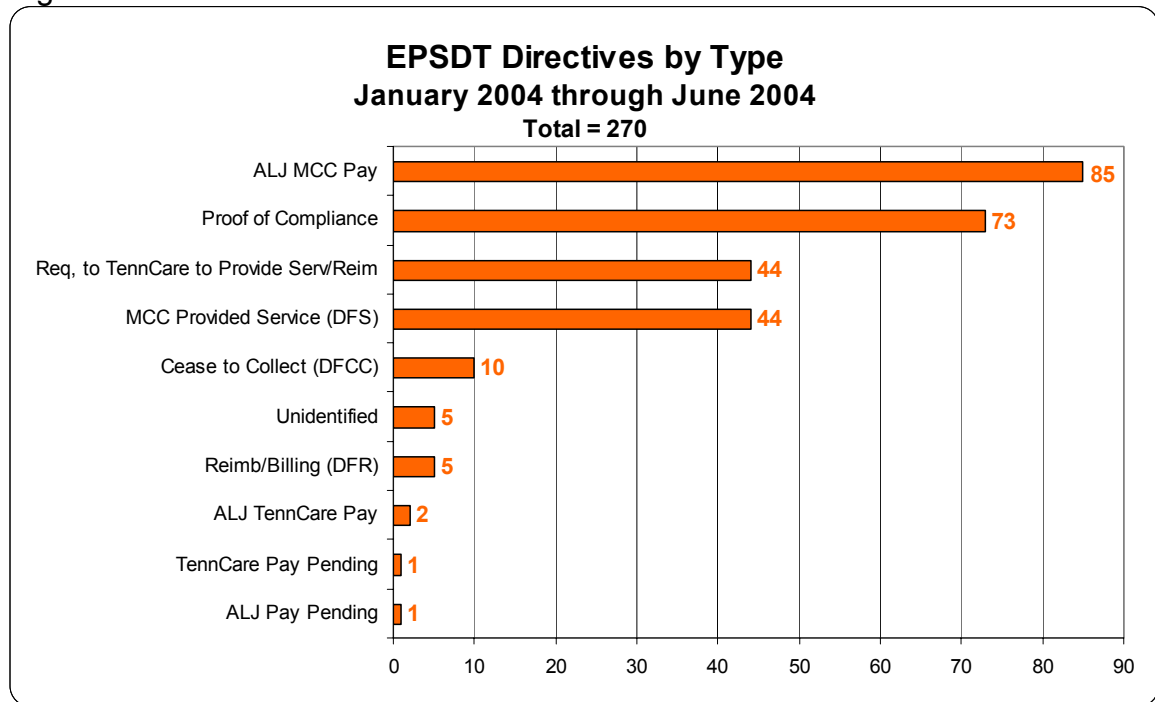




Figure 3.3

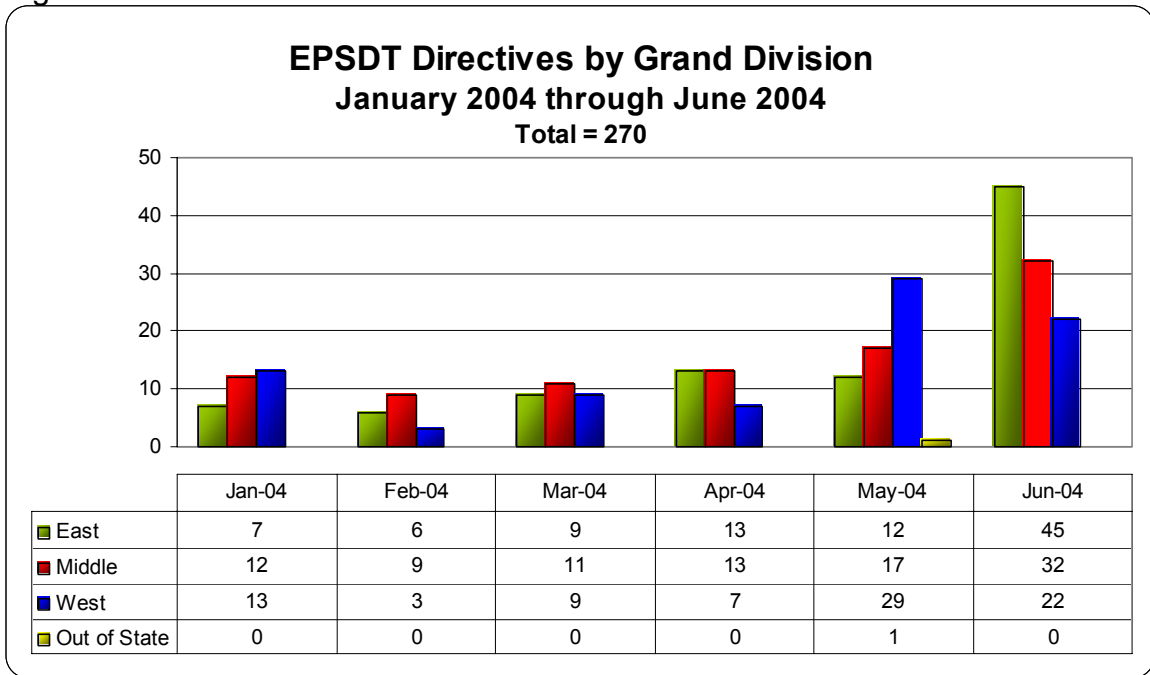


Figure 3.4

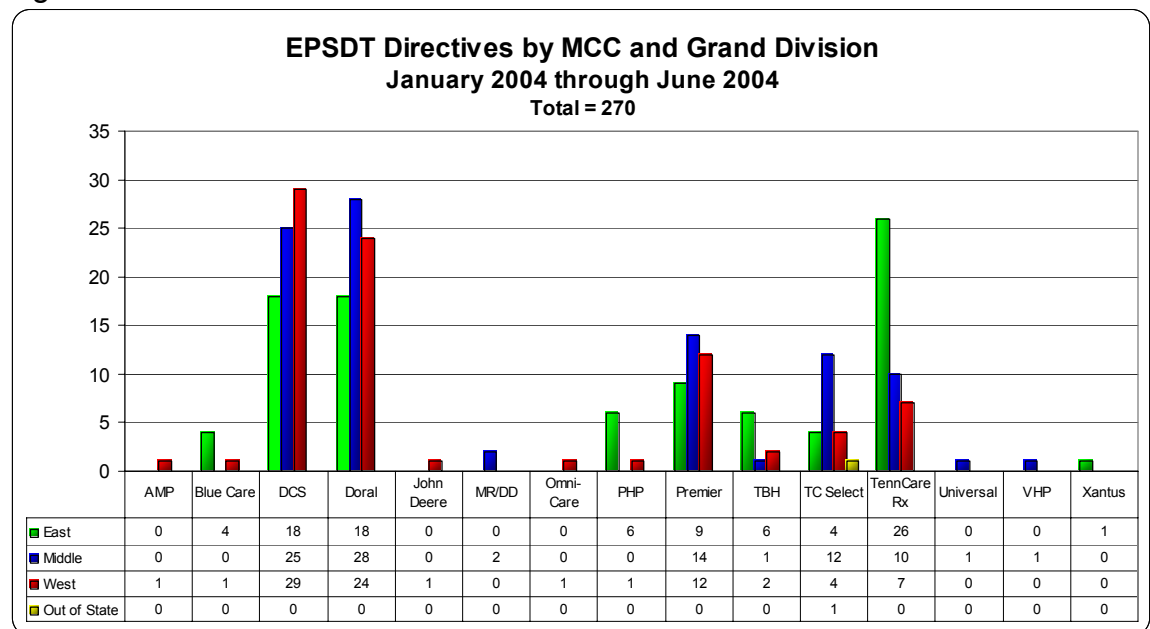
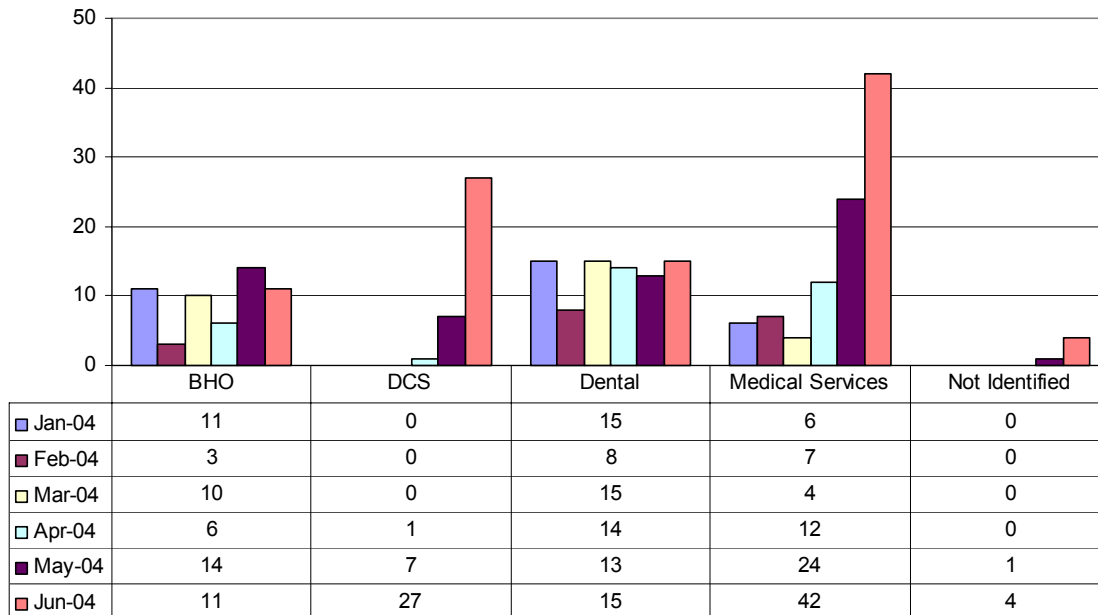


Figure 3.5

### EPSDT Directives by Service Group Classifications January 2004 through June 2004

Total = 270



# **Attachment A**

Tennessee Chapter of the American Academy of Pediatrics  
Summary of EPSDT/Coding Office Visits and Educational Programs  
April to June 2004

Introductory Office Visits

| Type of Office          | Number of visits completed (January-March 2004) | Number of visits completed (April-June 2004) | Number of visits completed (YTD) | Estimated Combined number of physicians in practices (April-June 2004) | Estimated Combined number of physicians in practices (YTD) | Comments   |
|-------------------------|---|--|----------------------------------|--|--|--|
| Pediatric offices       | 2   | 2  | 4                                | 10   | 23   | <u>Includes visits in:</u><br>Oak Ridge<br>Seymour<br>Oneida<br>Jefferson City<br>Powell<br>Cleveland<br>Jackson<br>Memphis<br>Sevierville<br>Bristol<br>Hixson<br>Clarksville<br>Columbia |
| Family Practice Offices | 8   | 4  | 12                               | 8  | 45   | See locations above  |
| Total                   | 10  | 6  | 16                               | 18   | 68   |  |

Tennessee Chapter of the American Academy of Pediatrics  
Summary of EPSDT/Coding Office Visits and Educational Programs  
April to June 2004

Expanded Office Visits/trainings

| Type of Visit  | Number of visits completed (January-March 2004) | Number of visits completed (April-June 2004) | Number of visits Completed (YTD) | Estimated Number of participants (April-June 2004) | Estimated Number of participants (YTD)    | Comments   |
|--|---|--|----------------------------------|--|---|--|
| Expanded visits (met with member of practice and had discussions about EPSDT, reviewed materials, obtained info requiring follow-up, etc.) | Pediatric<br>22<br><br>Family Practice<br>2     | Pediatric<br>18                              | 42                               | Pediatric<br>72                                    | 205<br>(number of physicians at practice) | See locations above  |
| Pediatric Society meetings   | 0   | 1  | 1                                | 45   | 45  | Knoxville Pediatric Society Meeting                              |
| Mock EPSDT audits  | 2   | 1  | 3                                | 5  | 21  | Cleveland Pediatrics,<br>Oak Ridge Pediatrics<br>Mercy Childrens |

| Type of Visit   | Number of visits completed (January-March 2004) | Number of visits completed (April-June 2004) | Number of visits Completed (YTD) | Estimated Number of participants (April-June 2004) | Estimated Number of participants (YTD) | Comments   |
|---|---|--|----------------------------------|--|--|--|
|   |   |  |                                  |  |  | Clinic   |
| Mock Coding audits  | 1   | 1  | 1                                | 5  | 15                                     | Oak Ridge Pediatrics<br>Mercy Childrens Clinic   |
| “Lunch and learn” with physician office or residents                      | 0   | 1  | 1                                | 13   | 13                                     | UT Family Practice<br>Knoxville Residents<br>EPSDT Training  |
| Formal training presentation at physician offices or on staff at hospital | 2   | Pediatric<br>4<br><br>Family Practice<br>1   | 7                                | 14   | 36                                     | Emergency Department<br>LeBonheur Basic and Advanced – 2<br>Training Sessions<br>Columbia Pediatrics<br>Ambulatory Care Center<br>Mercy Children’s Clinic<br>Mountain Peoples Health |

| Type of Visit | Number of visits completed (January-March 2004) | Number of visits completed (April-June 2004) | Number of visits Completed (YTD) | Estimated Number of participants (April-June 2004) | Estimated Number of participants (YTD) | Comments  |
|---------------|---|--|----------------------------------|--|--|---|
|               |   |  |                                  |  |  | Council<br>Childrens<br>Hospital Dr.<br>Lembersky |
| Total         | 29  | 27   | 55                               | 154  | 335                                    |   |

Regional / Regional Trainings  
(Sessions where multiple physicians and/or office staff  
are invited to training session in their regional area)

| Forum for sessions           | Number of sessions completed (January-March 2004) | Number of sessions completed (April-June 2004) | Number of sessions completed (YTD) | Number of participants (April-June 2004) | Number of participants (YTD) | Comments   |
|------------------------------|---|--|------------------------------------|--|------------------------------|--|
| EPSDT Coordinators Workgroup | 1   | 0  | 1                                  | 0  | 75                           | Conducted a formal training on the mock EPSDT audit process (2004 TennCare audit tool) for all MCO EPSDT Coordinators. MCO audit staff and TennCare audit staff participated on January 12, 2004. Follow-up training session scheduled for April 26, 2004. |
| Pediatric                    | 0   | 0  | 0                                  | 0  | 0                            | Scheduled for 2004   |

| Forum for sessions               | Number of sessions completed (January-March 2004) | Number of sessions completed (April-June 2004) | Number of sessions completed (YTD) | Number of participants (April-June 2004) | Number of participants (YTD) | Comments  |
|----------------------------------|---|--|------------------------------------|--|------------------------------|---|
| Society - Training               |   |  |                                    |  |                              |   |
| TNAAP PMN - Training             | 0   | 0  | 0                                  | 0  | 0                            | Scheduled for 2004  |
| TMA Workshops - Education        | 0   | 0  | 0                                  | 0  | 0                            | Scheduled for 2004  |
| LeBonheur Memphis - Training     | See Above Trainings at Emergency Department       | 0  | 0                                  | 0  | 0                            | Scheduled for 2004  |
| TAFP Convention - Education      | 0   | 0  | 0                                  | 0  | 0                            | Scheduled for 2004  |
| TNAAP CME Trainings - Education  | 0   | 0  | 0                                  | 0  | 0                            | Scheduled for 2004  |
| National Immunization Conference | 0   | 1  | 1                                  | 300                                      | 300                          | Attended National Immunization Conference at Opryland Convention Center in Nashville. TNAAP Display and educational materials and resources on EPSDT, Immunizations, Pediatric Coding, Safety and TNAAP. Four (4) day |



| Forum for sessions | Number of sessions completed (January-March 2004) | Number of sessions completed (April-June 2004) | Number of sessions completed (YTD) | Number of participants (April-June 2004) | Number of participants (YTD) | Comments    |
|--------------------|---|--|------------------------------------|--|------------------------------|-------------|
|                    |   |  |                                    |  |                              | conference. |
| Total              | 1   | 1  | 2                                  | 300                                      | 375                          |             |

Tennessee Chapter of the American Academy of Pediatrics  
Summary of EPSDT/Coding Office Visits and Educational Programs  
April to June 2004

**Other Related Activities**

| Type of Activity           | Number completed<br>(January-March 2004) | Number completed<br>(April-June 2004) | Number completed<br>(YTD) | Comments           |
|----------------------------|--|---------------------------------------|---------------------------|--------------------|
| EPSDT audits with TennCare | 0  | 0                                     | 0                         | Scheduled for 2004 |
| Total                      | 0  | 0                                     | 0                         |                    |

Grand Total's

| Number completed<br>(January-March 2004) | Number completed<br>(April-June 2004) | Number completed<br>(YTD) | Estimated Number of<br>physicians and<br>participants (YTD) |
|--|---------------------------------------|---------------------------|---|
| 40                                       | 34                                    | 74                        | 778   |

# **Attachment B**

**(see Mathematica Policy Research, Inc. report following  
attachment C)**

# **Attachment C**

**BUREAU OF TENNCARE**  
**Office of Contract Development and Compliance**  
**Record of Liquidated Damages Assessed**  
**01-01-04 through 06-30-04**

| <b>BHO/MCO</b> | <b>DATE OF<br/>ASSESSMENT<br/>NOTICE</b> | <b>Matter ID</b> | <b>EPSDT</b> | <b>DEFICIENCY<br/>ENROLLEE</b>   | <b>DATE TO<br/>FISCAL</b> | <b>TRACKING<br/>NUMBER</b> | <b>AMOUNT</b> |
|----------------|--|------------------|--------------|--|---------------------------|----------------------------|---------------|
| DCS            | 3/11/04                                  | 03-09-050-214914 | yes          | Late Documentation of Service<br>Independent Living Skills             | 3/16/04                   | None                       | \$7,000.00    |
| DCS            | 3/23/04                                  | 03-11-050-219628 | yes          | Late Documentation of Service<br>Psychological Evaluation & Counseling | 4/8/04                    | 04-002                     | \$6,500.00    |
| DCS            | 4/16/04                                  | 03-09-050-213674 | yes          | Delay of Service   | 4/22/04                   | 04-006                     | \$11,500.00   |
| PHP            | 5/10/04                                  | 04-03-014-234549 | yes          | Late Proof of Compliance<br>Payment for Provider Services              | 5/31/04                   | 04-009                     | \$9,000.00    |
| PHP            | 5/10/04                                  | 236864           | yes          | Late Response - On-Request Report<br>Cease to Bill                     | 5/31/04                   | 04-010                     | \$100.00      |
| BlueCare       | 5/24/04                                  | 03-07-002-205284 | yes          | Failure to provide notice requirement                                  | 5/31/04                   | 04-013                     | \$8,000.00    |
|                |  |                  |              |  |                           |                            | \$35,100.00   |

**BUREAU OF TENNCARE**  
**Office of Contract Development and Compliance**  
**Record of Liquidated Damages Assessed**  
**01-01-04 through 06-30-04**

| BHO/MCO | MATTER ID NUMBER | EPSDT | DATE OF<br>RESCISSION<br>NOTICE | DEFICIENCY<br>ENROLLEE                                    | DATE TO<br>FISCAL SERVICE | TRACKING<br>NUMBER | AMOUNT             | FULL<br>PARTIAL |
|---------|------------------|-------|---------------------------------|---|---------------------------|--------------------|--------------------|-----------------|
| MMC/TLC | 03-09-009-213932 | yes   | 1/16/04                         | Assessed while enrollee was<br>hospitalized               | 4/8/04                    | 04-001-R           | \$4,000.00         | partial         |
| PHP     | 04-03-014-234549 | yes   | 6/7/04                          | Late Proof of Compliance<br>Payment for Provider Services | 6/28/04                   | 04-005-R           | \$9,000.00         | full            |
|         |                  |       |                                 |   |                           |                    | <b>\$13,000.00</b> |                 |

Contract No.: FA-04-15588-00  
MPR Reference No.: 6074-400



**The EPSDT Program in  
Tennessee: Strategies for  
Enhancing Screening  
Percentages**

*April 29, 2004*

*Henry T. Ireys  
Tara Krissik*

Submitted to:

Manny Martins, Deputy Commissioner  
Tennessee Department of Finance  
and Administration  
Bureau of TennCare  
729 Church Street  
Nashville, Tennessee 37247

Project Officer: Susie Baird

Submitted by:

Mathematica Policy Research, Inc.  
600 Maryland Ave., SW, Suite 550  
Washington, DC 20024-2512  
Telephone: (202) 484-9220  
Facsimile: (202) 863-1763

Project Director: Henry T. Ireys

## CONTENTS

| Chapter  | Page |
|--|------|
| EXECUTIVE SUMMARY .....  | iv   |
| I. INTRODUCTION .....  | 1    |
| A. OVERVIEW .....  | 1    |
| B. RECENT EFFORTS BY TENNESSEE TO MONITOR<br>AND IMPROVE THE EPSDT PROGRAM .....             | 3    |
| C. REQUEST FOR CLARIFYING TIMELINES FOR<br>ACCOMPLISHING SPECIFIC SCREENING OBJECTIVES ..... | 6    |
| D. PURPOSE AND OVERVIEW OF REPORT .....  | 6    |
| II. PROJECTIONS FOR ACHIEVING SCREENING OBJECTIVES .....                                     | 8    |
| A. CURRENT METHODS FOR CALCULATING<br>SCREENING PERCENTAGES .....                            | 8    |
| B. GENERATING PROJECTIONS FOR HEALTH SCREENS .....   | 10   |
| C. GENERATING PROJECTIONS FOR DENTAL SCREENS .....   | 13   |
| III. SPECIFIC ACTIVITIES TO ENHANCE SCREENING RATES .....                                    | 14   |
| A. ENROLLEE OUTREACH.....  | 14   |
| 1. Influential Factors .....   | 14   |
| 2. Specific Activities.....  | 16   |
| 3. Current Schedule .....  | 18   |
| B. PROVIDER EDUCATION AND PARTICIPATION .....  | 19   |
| 1. Influential Factors .....   | 19   |
| 2. Specific Activities.....  | 20   |
| 3. Current Schedule .....  | 23   |



## CONTENTS *(continued)*

| Chapter                                      | Page |
|--|------|
| C. SCREENING DATA .....                      | 24   |
| 1. Influential Factors .....                 | 24   |
| 2. Specific Activities.....                  | 26   |
| 3. Current Schedule .....                    | 27   |
| D. PROGRAM MONITORING AND COORDINATION ..... | 27   |
| 1. Influential Factors .....                 | 27   |
| 2. Specific Activities.....                  | 30   |
| 3. Current Schedule .....                    | 32   |
| IV. SUMMARY.....                             | 33   |
| REFERENCES .....                             | 35   |

## EXECUTIVE SUMMARY

A critical component of the class action lawsuit filed against Tennessee, *John B. v. Menke*, was the state's failure to provide comprehensive health and dental screenings to a substantial portion of children eligible for such services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Under the Consent Decree negotiated between the parties in 1998, the state was required to reach the 80 percent level in 2001 for health screenings and in 2003 for dental screenings or to show that all children who have not received complete screenings have been the subject of outreach efforts reasonably calculated to ensure their participation. Tennessee has been unable to meet these objectives. The court, through a special master, recently asked the state to submit a plan showing how it intends to meet these requirements in a timely manner.

The purpose of this report is to assist Tennessee by providing a framework for analyzing the percentage of children who receive screening services and presenting projections for the growth in the percent of children receiving health and dental screenings. The report also describes what the state is doing or plans to do to enhance screening rates. In connection with this, we identify four sets of factors (parental and adolescent decision-making, availability of and access to primary care providers, provider knowledge and capacity, and data-related procedures) that can influence screening percentages.

We gathered information for this report by reviewing documents on the calculation of screening percentages in Tennessee (including the most recent Itemized Assessment Protocol submitted to the court), by interviewing selected state staff responsible for compiling and analyzing EPSDT data, and by reviewing activity reports from state departments involved in EPSDT.

Our projections are based on three alternative scenarios about the growth in the screening percentage for eligible children (as reported on line 7 of CMS Form 416) and about growth in the number of children who are estimated to have a full set of screens (as determined by on-site medical record reviews). These scenarios are that the CMS 416 percentage will grow by:

- 7.5 percent each year, which would continue the average increase in the screening ratio observed during the previous six years; this rate of growth means that the adjusted periodic screening percentage (APSP)<sup>1</sup> will reach 80 in 2009
- 5 percent each year, which assumes a growth rate that is lower than recent trends; this rate of growth means that the APSP will reach 80 in 2011
- 10 percent each year, which assumes a growth rate that is higher than recent trends; this rate of growth means that the APSP will reach 80 in 2007

---

<sup>1</sup>The APSP “adjusts” the screening ratio reported on line 7 of the CMS Form 416. The adjustment is made by multiplying the Form 416 screening ratio by the percentage of the required seven components that have been documented through a review of medical records of a statistically significant sample of TennCare-enrolled children receiving screens.

Guided by a general strategic plan, Tennessee has established a series of workgroups that have begun or planned a wide range of activities that are designed to enhance screening percentages. These include a multifaceted enrollee outreach campaign, programs to enhance provider education and increase provider participation in the EPSDT program, improvements in data collection and analysis, and development of tools and strategies for monitoring the EPSDT program and measuring progress toward specific objectives. Although these various activities are likely to improve screening percentages, predicting the rate of increase is difficult because of the many factors that influence health and dental screenings.

Overall, we suggest that Tennessee continue to focus on strengthening the EPSDT program and to monitor progress toward the achievement of specific screening goals. Monitoring should include tracking changes not only in the percentage of children screened and percentage of expected screenings actually provided (as indicated on Form 416) but also in the percentage of well-child visits that included all EPSDT components (as indicated by on-site medical record reviews). Other critical activities related to screening should include 1) comparative analyses of the growth in screening percentages for specific age groups in order to develop appropriate age-specific interventions and 2) improved data collection strategies that would allow the state to more accurately and efficiently track the provision of basic EPSDT-related screenings.

## I. INTRODUCTION

### A. OVERVIEW

The state of Tennessee reported that children enrolled in TennCare received 54 percent of the preventive health screens they should have received through the state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program in federal fiscal year 2002.<sup>1</sup> This percentage has risen from 36 percent in fiscal year 1999. The state also reported that eligible children received 36 percent of the dental screenings they should have received in fiscal year 2002, up from 29 percent in fiscal year 1999. The state's failure to provide health and dental screenings to a substantial portion of TennCare children led to a class action suit filed against Tennessee in 1998 (*John B. v. Menke*).

Enhancing the number of children who receive preventive health and dental screenings through the EPSDT program is an important goal for Tennessee. As numerous reports indicate (e.g., Leatherman and McCarthy, 2004), preventive care can benefit children by promoting healthy development, reducing morbidity, and preventing the onset of serious physical and behavioral problems. Establishing specific and realistic objectives for enhancing screening percentages is an essential component of an organized, multifaceted effort to increase the number of children enrolled in TennCare who receive comprehensive preventive health and dental screenings and to improve monitoring of the EPSDT program. Overall, Tennessee offers insurance coverage to many children who are not eligible for Medicaid, thus increasing access to health services, including preventive health care.

---

<sup>1</sup>Figure from Line 7, CMS Form 416 for FY 2002, submitted by the State of Tennessee to CMS in 2003.

The parties in *John B.* developed an agreement specifying the steps that Tennessee would take to improve the EPSDT program. This agreement was the basis for the court's Consent Decree, entered in March 1998, that instructed Tennessee, among other matters, to increase the adjusted periodic screening percentage (APSP) consistently so as to achieve an 80 percent APSP in federal fiscal year 2001.<sup>2</sup> The Consent Decree also required the state to increase the dental screening percentage (DSP) consistently so as to achieve an 80 percent dental screening percentage (DSP) for federal fiscal year 2003 and specified how the DSP should be calculated.<sup>3</sup>

Tennessee was unable to meet objectives specified in the Consent Decree and, in the summer of 2001, the court held further hearings in response to a motion from the plaintiffs to find Tennessee in contempt. These hearings led to a confirmation that the state is in violation of federal EPSDT law and an abeyance of the contempt finding. The court also appointed a special master to fairly, effectively, and timely evaluate the implementation of the Consent Decree and EPSDT law.<sup>4</sup>

---

<sup>2</sup>The APSP “adjusts” the screening ratio reported on line 7 of the current CMS Form 416. The adjustment is made by multiplying the Form 416 screening ratio by the percentage of the required seven components that have been documented through a review of medical records of a statistically significant sample of TennCare-enrolled children receiving screens. The APSP is discussed further in Chapter II.

<sup>3</sup>Paragraph 46 of the Consent Decree states, in part: “[U]tilizing a frequency standard of one screen per year per child for ages three through twenty, HCFA 416 methodology, and dental encounter codes specified by TennCare, the TennCare Bureau will calculate a baseline dental screening ratio for the period from October 1, 1995 through September 30, 1996. This baseline dental screening ratio will be multiplied by 100 to calculate the baseline dental screening percentage (DSP).”

<sup>4</sup>Order of the U.S. District Court for the Middle District of Tennessee, Nashville Division on August 14, 2002.

## **B. RECENT EFFORTS BY TENNESSEE TO MONITOR AND IMPROVE THE EPSDT PROGRAM**

Within the last several months, Tennessee has taken critical steps to improve the EPSDT program and the state's capacity for monitoring progress toward specific program objectives.<sup>5</sup> One of the most important steps has been to develop plans for establishing five workgroups:

- Enrollee Outreach
- Provider Education and Participation
- Screening and Referral Data
- Program Monitoring and Coordination
- Diagnosis and Treatment

Overall, these workgroups will be held accountable for taking specific steps to improve the EPSDT program. Table I.1 presents the initial mission statements for each workgroup.

Figure I.1 provides a framework for tracking activities that specifically influence screening percentages and indicates the workgroups whose activities are related to each step. Figure I.1 suggests that there are seven critical steps in the process that leads to the final screening percentage. The first involves the family's decision to make and keep an appointment for well-child care (with assistance as needed). The Enrollee Outreach workgroup is working on developing and implementing activities relevant to this component.

---

<sup>5</sup>A comprehensive description of the current status of all of these activities is beyond the scope of this report. A general plan for improving the EPSDT program was outlined in a previous report (Ireys, Krissik, and Rosenbach 2003) and an update on the plan will be the focus of a subsequent report.

TABLE I.1

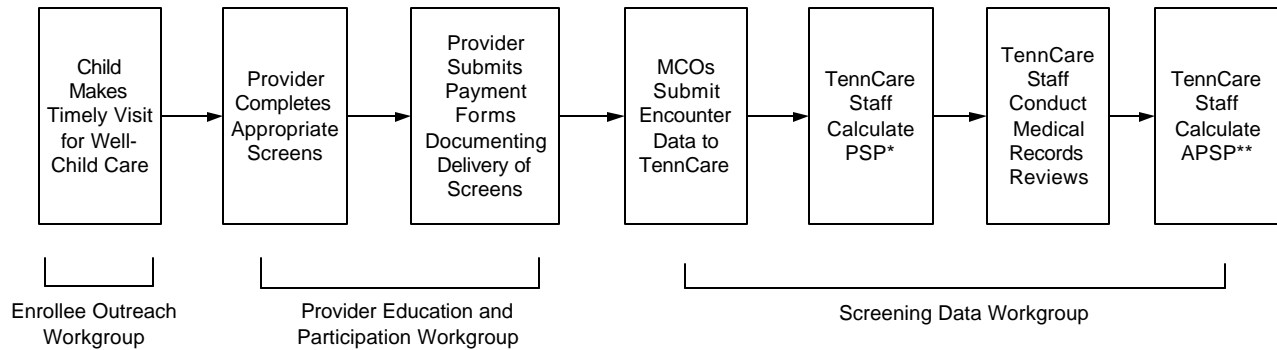
## WORKGROUPS ESTABLISHED TO IMPROVE THE EPSDT PROGRAM IN TENNESSEE

| Workgroup                            | Initial Mission Statement  | Month of First Meeting |
|--------------------------------------|--|------------------------|
| Enrollee Outreach                    | To develop, support, and monitor efforts to broaden awareness of the EPSDT program and the need for preventive health screenings for people under 21 years of age  | January 2004           |
| Provider Education and Participation | To ensure adequacy of PCP and specialty provider networks by generating support from the provider community for the EPSDT program and by providing needed educational programs   | March 2004             |
| Screening and Referral Data          | To develop an effective method for monitoring the delivery of the seven basic screens and documenting which children are referred from a PCP to a specialist for further evaluation or treatment   | April 2004             |
| Program Monitoring and Coordination  | To develop effective management tools that will provide continuing capacity to monitor program change and track progress toward short-term and long-term goals   | To be Announced        |
| Diagnosis and Treatment              | To ensure that all children referred for further evaluation and treatment have access to appropriate Medicaid specialty providers (medical, dental, and mental health) and that treatment services are coordinated on behalf of at-risk children | To be Announced        |

- NOTES:
1. Mission statements may be revised somewhat as workgroups continue to meet.
  2. In lieu of designated committee members, for the Program Monitoring and Coordination workgroup, MPR and designated staff from the Governor's Office and TennCare have been working to monitor and coordinate selected workgroups since January 2004. These individuals are working to develop management tools that will allow for efficient tracking of all workgroup activities and achievement of specific workgroup objectives.

FIGURE I.1

FRAMEWORK FOR ANALYZING TENNESSEE EPSDT SCREENING  
PERCENTAGES AND ASSOCIATED WORKGROUPS



NOTE: Each workgroup has additional areas of responsibility beyond those indicated here.

\*PSP: Periodic Screening Percentage

\*\*APSP: Adjusted Periodic Screening Percentage. The PSPs are adjusted based on information collected during the medical record reviews.

The second two components involve actions undertaken by the PCP, including the actual delivery of the seven basic components of an EPSDT screen and documentation that a comprehensive well-child exam was completed. The Provider Education and Participation workgroup is working on developing and implementing activities relevant to these components.

The final components involve the gathering of relevant data on screening activities, ensuring that data are as valid and accurate as possible, and making necessary calculations based on appropriate assumptions. The Screening and Referral Data workgroup will be working to develop and implement activities relevant to these components.

Specific activities underway or planned by these workgroups are discussed further in Chapter III.



### **C. REQUEST FOR CLARIFYING TIMELINES FOR ACCOMPLISHING SPECIFIC SCREENING OBJECTIVES**

The special master asked Tennessee to provide an indication of when it would achieve the 80 percent objective for the APSP and the DSP. After first proposing that this objective could be achieved by 2008, Tennessee revised its projection and in late February 2004 provided the special master with materials 1) indicating that the state expected to achieve an 80 percent APSP and DSP no later than federal fiscal year 2006 and 2) outlining various activities that would accelerate progress toward these objectives. At a meeting with the plaintiffs and the state's counsel in late March 2004, the special master communicated that the materials fell short of a "good and feasible" plan and instructed Tennessee to complete such a document.

### **D. PURPOSE AND OVERVIEW OF REPORT**

The purpose of this report is to assist the state in responding to the request from the special master. We developed this report by reviewing documents provided to us by state officials and by conducting brief telephone interviews with key personnel in TennCare and other state departments. This report:

- Describes specifically how the state calculates the APSP and DSP and outlines three scenarios for increasing the APSP and DSP over current levels
- Presents a brief overview of the factors that influence screening percentages in the EPSDT program
- Describes specific activities underway or planned by each workgroup that are designed to enhance screening percentages

Specifically, Chapter II includes a description of how Tennessee calculates the APSP and DSP and presents projections of the growth in these percentages based on assumptions about the increase in the percentage of screenings provided as indicated on the CMS Form 416 and in the percentage of complete screens documented through chart review. We outline three scenarios

based on varied assumptions about growth rates and calculated the year in which the APSP and DSP will reach 80 under each scenario.

Tennessee has initiated a series of activities that are designed to improve the EPSDT program overall and the state's capacity to measure progress toward specific program objectives. Many of these activities are directly related to screening percentages. Although the state has initiated and will continue to support improvements in the EPSDT program overall, the net effect of these efforts on screening percentages is uncertain because there are multiple factors that influence screening percentages. Chapter III identifies these factors, some of which can be directly influenced by the state through the workgroups noted above and some of which are beyond the state's capacity to influence. Any projection of a timetable for achieving a specific screening percentage is necessarily conditional on these factors.

Chapter III also describes activities that are underway or planned by designated workgroups that are likely to enhance screening percentages. This list represents a current inventory of strategies and is likely to expand because the workgroups are continuing to meet and to identify new ideas and strategies. Chapter IV concludes the report with a brief summary of key points.

## **II. PROJECTIONS FOR ACHIEVING SCREENING OBJECTIVES**

Projecting Tennessee's attainment of specific screening objectives depends on a thorough understanding of what measures are used to calculate screening percentages and what assumptions are made about future growth. In this chapter, we first examine current methods for calculating the APSP and DSP and then outline specific projections for attaining an APSP and DSP of 80 percent, based on selected assumptions about the rate of increase in critical measures.

### **A. CURRENT METHODS FOR CALCULATING SCREENING PERCENTAGES**

Tennessee uses the standard instructions provided by CMS to calculate figures for Form 416 based on analysis of claims and eligibility data in the Medicaid Management Information System. Screening figures are calculated on the basis of a federal fiscal year (October 1 – September 30) and CMS asks that the completed Form 416 be sent six months after the close of a given fiscal year (April 1). The state has written detailed computer specifications to operationalize the CMS instructions. Minor revisions, made in early 2003, affected the calculations of the federal fiscal year 2002 figures.<sup>6</sup>

In addition to calculating the percent of expected screens that were actually provided in a given fiscal year as specified on the CMS Form 416 (line 7), Tennessee also calculates an “adjusted periodic screening percentage” (APSP). This figure was developed to account for the fact that standard diagnostic and billing codes do not accurately reflect the number of EPSDT-

---

<sup>6</sup>In light of the specific changes, we would expect their impact on screening percentages to be minor, but we did not conduct a statistical analysis to examine this issue.

related screens that were actually provided. The APSP is designed, therefore, to reflect the “true” percentage of children who received all components of an EPSDT screen.<sup>7</sup>

The APSP is calculated by multiplying the screening ratio (as indicated by line 7 on Form 416) by an estimate of the percentage of children estimated to have received all components of an EPSDT screen (as determined by on-site medical record reviews). This estimate is derived from on-site chart reviews of a random sample of children. To derive the adjustment factor for fiscal year 2002, charts were reviewed for a total of 4,405 individuals, a sample size that provided estimates of completion rates for each of the 10 MCOs within acceptable margins of error.<sup>8</sup>

The Consent Decree specifies that Tennessee should have reached an 80 percent APSP by fiscal year 2001. This means that both the Form 416 percentage *and* the completion percentage must be quite high. For example, if the screening percentage is 80 and if the screenings these children receive contain 80 percent of the required components, the APSP would be only .64 (.80 x .80).

The 80 percent APSP could be reached if any of the following occurred:

- The CMS Form 416 percentage is 80 and the completion percentage determined by chart review is 100 (.80 x 1 = .80). This situation is implausible, however, because not all PCPs will document or complete all screens for all children and thus the completion percentage is not likely to reach 100.

---

<sup>7</sup>The APSP is a Tennessee-specific measure developed as a method for compensating for the fact that Tennessee does not require providers to bill each component of the screen separately.

<sup>8</sup>The specific diagnostic and procedure codes used in the selection process for the fiscal year 2002 chart review sample differed slightly from the codes used to calculate the CMS Form 416 figures for the same fiscal year. As a result, the sample drawn for the chart reviews does not match precisely the population on which the Form 416 figures were calculated. This is likely to introduce a small amount of error into the final adjusted figure, but we did not investigate whether the error is likely to lead to an over-or under-estimate of the true completion percentage.

- The CMS Form 416 percentage is 90 and the completion percentage determined by chart review is 90 ( $.90 \times .90 = .81$ ). This situation is also implausible because the Form 416 percentage is not likely to reach 90. The cumulative effect of the multiple factors described in Chapter III is likely to be sufficiently strong so as to prevent the delivery and documentation of 90 percent of expected screens.
- The CMS Form 416 percentage is .85 and the completion percentage determined by chart review is 95 ( $.85 \times .95 = .81$ ). Although the Form 416 percentage might reach 85 only under ideal conditions, this situation is the most plausible of the possible outcomes.

The Consent Decree indicates that the DSP is to be calculated using a frequency standard of one screen for each child aged 3 through 20, CMS Form 416 methodology, and dental encounter codes specified by TennCare. However, the CMS Form 416 instructions do not provide any specific methodology for calculating the percentage of children receiving any of the three types of dental services included in the form (i.e., any dental service, preventive dental service, or dental treatment service). The specific operational formula used by Tennessee for calculating the DSP is based on the total number of eligible children aged 3 through 20 (adjusted for number of months enrolled in TennCare) and the number of TennCare children receiving any dental services (line 12a on the CMS Form 416). Any American Dental Association encounter code is used to determine whether a child received a dental screening.

## **B. GENERATING PROJECTIONS FOR HEALTH SCREENS**

As noted previously, the Form 416 screening percentage was 54 in fiscal year 2002. According to a report from the Division of Quality Oversight, the annual medical record review indicated that the completion percentage was 77.7 in fiscal year 2002. Using these fiscal year 2002 figures as a starting point, we projected when Tennessee would reach an APSP of 80 based on three different scenarios. We developed these projections by taking two steps.

First, we examined data on CMS Form 416 for the six years between 1996 and 2002, and found that the screening percentage of children who received at least one screen increased an

average of 7.3 percent per year. Therefore, our first scenario is based on the assumption that a similar increase in the percentage will occur in the future. Specifically, we assumed that there would be a 7.5 percent increase in the Form 416 percentage. We then developed scenarios where the percent of children screened is assumed to grow by 5 percent (an assumption of a growth rate that is lower than recent trends) and by 10 percent (an assumption of a growth rate that is higher than recent trends).

Second, we made corresponding assumptions about the rate of increase in the completion percentage (also termed the record review percentage). We elected not to use past figures to calculate future growth in the completion percentage because the procedures for conducting medical record reviews and the sample size changed considerably in the last five years; as a result, any calculation of a past average percentage could be misleading.

Table II.1 presents our projections based on 1) the three scenarios regarding the increase in the Form 416 screening percentage and 2) our assumptions about changes in the record review percentages. This table shows the following:

- If the 416 percentage increases by *5 percent* each year, the APSP will reach 80 in the year 2011, regardless of the rate of increase in the record review percentage. The record review percentage reaches its maximum plausible level in 2005 or 2006 depending on the assumption about its rate of increase, but APSP growth is limited by the relatively slow increase in the 416 percentage.
- If the 416 percentage increases by *7.5 percent* each year, the APSP will reach 80 in 2009
- If the 416 percentage increases by *10 percent* each year, the APSP will reach 80 in the year 2007

Determining what projection is the most realistic depends on a variety of factors, including the number of well-child appointments that children and adolescents make and keep, the number of children and adolescents who receive complete screens, the number of these screens that are

TABLE II.1

**PROJECTED INCREASES IN FORM 416 SCREENING PERCENTAGES, RECORD REVIEW (RR) COMPLETION PERCENTAGES,  
AND ADJUSTED PERIODIC SCREENING PERCENTAGES (APSP) FROM 2003, BY THREE SCENARIOS**

| Scenario | 416<br>Increase | RR<br>Increase | 2003 |      |      | 2004 |      |      | 2005 |      |      | 2006 |      |      | 2007 |      |      | 2008 |      |      | 2009 |      |      | 2010 |      |      |
|----------|-----------------|----------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
|          |                 |                | 416  | RR   | APSP | 416  | RR   | APSP | 416  | RR   | APSP | 416  | RR   | APSP | 416  | RR   | APSP | 416  | RR   | APSP | 416  | RR   | APSP | 416  | RR   | APSP |
| I        | 5               | 5              | 56.7 | 81.6 | 46.3 | 59.5 | 85.7 | 51.0 | 62.5 | 89.9 | 56.2 | 65.6 | 94.4 | 62.0 | 68.9 | 95.0 | 65.5 | 72.3 | 95.0 | 68.7 | 75.9 | 95.0 | 72.1 | 79.7 | 95.0 | 75.7 |
|          | 5               | 7.5            | 56.7 | 83.5 | 47.4 | 59.5 | 89.8 | 53.5 | 62.5 | 95.0 | 59.4 | 65.6 | 95.0 | 62.3 | 68.9 | 95.0 | 65.5 | 72.3 | 95.0 | 68.7 | 75.9 | 95.0 | 72.1 | 79.7 | 95.0 | 75.7 |
|          | 5               | 10             | 56.7 | 85.5 | 48.5 | 59.5 | 94.0 | 56.0 | 62.5 | 95.0 | 59.4 | 65.6 | 95.0 | 62.3 | 68.9 | 95.0 | 65.5 | 72.3 | 95.0 | 68.7 | 75.9 | 95.0 | 72.1 | 79.7 | 95.0 | 75.7 |
| II       | 7.5             | 5              | 58.1 | 81.6 | 47.4 | 62.4 | 85.7 | 53.5 | 67.1 | 89.9 | 60.3 | 72.1 | 94.4 | 68.1 | 77.5 | 95.0 | 73.6 | 83.3 | 95.0 | 79.1 | 85.0 | 95.0 | 80.8 |      |      |      |
|          | 7.5             | 7.5            | 58.1 | 83.5 | 48.5 | 62.4 | 89.8 | 56.0 | 67.1 | 95.0 | 63.7 | 72.1 | 95.0 | 68.5 | 77.5 | 95.0 | 73.6 | 83.3 | 95.0 | 79.1 | 85.0 | 95.0 | 80.8 |      |      |      |
|          | 7.5             | 10             | 58.1 | 85.5 | 49.6 | 62.4 | 94.0 | 58.7 | 67.1 | 95.0 | 63.7 | 72.1 | 95.0 | 68.5 | 77.5 | 95.0 | 73.6 | 83.3 | 95.0 | 79.1 | 85.0 | 95.0 | 80.8 |      |      |      |
| III      | 10              | 5              | 59.4 | 81.6 | 48.5 | 65.3 | 85.7 | 56.0 | 71.9 | 89.9 | 64.6 | 79.1 | 94.4 | 75.1 | 85.0 | 95.0 | 80.8 |      |      |      |      |      |      |      |      |      |
|          | 10              | 7.5            | 59.4 | 83.5 | 49.6 | 65.3 | 89.8 | 58.7 | 71.9 | 95.0 | 68.3 | 79.1 | 95.0 | 75.1 | 85.0 | 95.0 | 80.8 |      |      |      |      |      |      |      |      |      |
|          | 10              | 10             | 59.4 | 85.5 | 50.8 | 65.3 | 94.0 | 61.4 | 71.9 | 95.0 | 68.3 | 79.1 | 95.0 | 75.1 | 85.0 | 95.0 | 80.8 |      |      |      |      |      |      |      |      |      |

416 = CMS Form 416

RR = Record Review

APSP = Adjusted Periodic Screening Percentage, calculated by multiplying the 416 percent by the RR percent.

NOTES

1. Baseline starts with FY 2002 CMS 416 percentage of 54 (from line 7) and medical record review completion percentage of 77.7.
2. We are assuming that the record review will never show 100 percent completion because PCPs are unlikely to complete all screens on every well-child visit. We are assuming that 95 is the maximum plausible completion percentage.
3. We also are assuming that the 416 percentage will never reach 100 percent because of the multiple factors affecting well-child care, as described in Chapter II. We are assuming that 85 is the maximum plausible 416 percentage.
4. These two assumptions place an upper limit of 80.8 percent (.85 x .95) on the APSP, suggesting that the objective of reaching an APSP of 80 percent can only be reached if the other two factors are at their maximum plausible percentages.
5. In the first scenario, the APSP reaches 80.8 in 2011. These data are not shown because of space limitations.

adequately documented, and potential changes in data input and analysis. Also, growth in the percentage of children who receive health screens may be expected to decrease because growth rates can taper off as more and more of the target population use a specific service. This phenomenon could occur because successful efforts to encourage the target group to use a particular service leave only hard-to-reach individuals who are not using the service. More and more effort may be required to reach fewer and fewer individuals. Consequently, it becomes difficult to maintain similar rates of growth over time.

### **C. GENERATING PROJECTIONS FOR DENTAL SCREENS**

We completed projections for the dental screening percentage using increases similar to the ones we used for the health screening percentage. For the DSP, we began with a starting point of 36 in fiscal year 2002, as reported in various court documents. We then increased the 2002 DSP by 5, 7.5, or 10 percent each subsequent year. We found:

- If the DSP increases by *5 percent* each year, it will be not reach 80 until well beyond 2013
- If the DSP increased by *7.5 percent* each year, it will reach 80 by 2013
- If the DSP increases by *10 percent* each year, it will reach 77 by 2010 and 85 by 2011

Again, determining what projection is the most realistic depends on a variety of factors, including the opportunities that children and adolescents have for dental screenings, the willingness of children to go for dental screenings (and for their parents to take them), the number of children and adolescents who actually receive these screenings, the number of these screenings that are adequately documented, and potential changes in data input and analysis. As with the percentage of children who receive health screenings, the rate of growth in the percent of children who receive dental screenings may be difficult to sustain over time.



### **III. SPECIFIC ACTIVITIES TO ENHANCE SCREENING RATES**

The EPSDT program includes multiple components, three of which are especially relevant for calculating screening percentages: enrollee outreach, provider education and participation, and documentation and reporting of screening activities. Tennessee's efforts to improve screening rates for EPSDT involve an array of interlocking activities related to these components. Designated workgroups have or will have responsibility for implementing or tracking the implementation of these activities according to a schedule.

In this chapter, we re-visit the framework described in Chapter I (see Figure I.1) and focus on the following three workgroups:

- Enrollee Outreach
- Provider Education and Participation
- Screening Data

For each workgroup we identify: (1) influential factors that will influence screening percentages, (2) specific activities and the rationale for why they should lead to improved screening percentages, and (3) a current schedule for workgroup activities. In addition, we discuss activities underway and planned that will focus on monitoring these workgroups and coordinating their multiple and varied efforts.

#### **A. ENROLLEE OUTREACH**

##### **1. Influential Factors**

Numerous, interacting factors are likely to influence parental decision-making in relation to child health care. For example, analyses of data from the 2000 Medical Expenditure Panel Survey (AHRQ 2002) indicate that "parents' perceptions of accessibility of care may affect care-

seeking behavior, such as whether to use routine primary care or visit the ER” (Leatherman and McCarthy 2004 p. 7). Various other factors also may shape parents’ decisions to make a preventive care visit, including a basic understanding of the value of preventive care; the presence of other, urgent family needs that decrease the time and resources required to make and keep appointments for preventive health care (especially if PCP offices or health clinics are far away or require extended travel on public transportation); the disruptive effects of moves and other serious life events; both the direct and indirect costs associated with taking a child to a doctor’s office or health clinic; and difficulties in getting time off from work to take a healthy child to a well-child visit.

Several studies suggest that between 15 and 25 percent of parents, regardless of income and insurance status, do not ensure that their children receive preventive services. For example, data from the 1999 National Survey of America’s Families indicate that low-income and publicly insured children were *more* likely to receive recommended preventive health care visits than children whose family income was above the poverty line or children with private insurance (Leatherman and McCarthy 2004; Yu et al. 2002). Specifically, 24 percent of children in families earning more than 300 percent of the poverty level did not receive recommended well-child care compared with 17 percent of children in families with incomes less than poverty level; furthermore, 24 percent of privately insured children did not receive recommended well-child care compared with 15 percent of children with public insurance (Yu et al. 2002).

Families will be less likely to decide to seek preventive care if they cannot easily reach a PCP’s office. In rural areas, families need access to a car in order to reach physician offices or public health clinics, and this may be difficult for some families. In urban areas, families that do not own a car may be dependent on public transportation or on family or friends to take them to a doctor’s office. Again, depending on their particular location and situation, families may find

these sources of transportation to be unreliable, dangerous, or expensive. In response to these concerns, TennCare covers non-emergency transportation for any enrollee who lacks access to transportation, including enrollees who own a car but cannot afford to buy gasoline.

As they grow toward adulthood, adolescents assume increasing responsibility for their health and health care, and effective outreach efforts or informational campaigns must be based on a sound understanding of how teenagers make decisions about health care. In general, adolescents are less likely to have preventive care visits compared with younger children. According to one study (Yu et al. 2002), 66 percent of all adolescents aged 15 to 17 had an annual well-child visit compared with 81 percent of children aged 3 to 4 and 84 percent of children aged 5 to 10. This differential rate underscores the importance of age-specific interventions designed to improve screening percentages and the value of TennCare's outreach efforts focused specifically on adolescents.

The final outcome of efforts to enhance the percentage of children who receive screening services depends first on the parent's and adolescent's decision to make and keep appointments for well-child visits. Public health programs, MCOs, and health care professionals can support parents and teenagers in this process by developing educational materials that support their decisions to seek preventive care.

## **2. Specific Activities**

Tennessee's Enrollee Outreach workgroup is implementing or tracking the implementation of a range of activities, including the following:<sup>9</sup>

---

<sup>9</sup>There are also other, ongoing activities related to enrollee outreach in various departments. For example, staff in local health departments routinely inform TennCare enrollees about EPSDT whenever possible, such as during WIC visits.

- Promoting new names (TENNderCARE and TeenCare) and new logos through diverse media including television advertisements and brochures, and distribution of materials in schools, clinics, physician offices, and other sites. A separate name is being used for the adolescent population to assist in developing marketing materials appropriate to this age group. Over time, outreach content will be developed specifically for special populations such as special needs children, foster families, and adolescents.
- Implementing train-the-trainer sessions that will provide a consistent introduction and overview of EPSDT services to key employees of state departments involved in the administration and provision of EPSDT services (including Department of Health, TennCare, and others) and to appropriate staff in the MCOs. The trained trainers will then serve as resources and sources of information for other staff in their departments or organizations. Initial interviews assessing the trainer's knowledge will result in modification of materials as needed.
- Tracking the EPSDT Community Outreach campaign. The Department of Health, the Governor's office, TennCare, the Departments of Education and Human Services, and others are collaborating to implement the campaign before the 2004-2005 school year begins. The goal of this broad, public awareness campaign is to raise EPSDT awareness among TennCare enrollees and includes specific components designed to reach older children.
- Tracking the implementation of the EPSDT Outreach Call Center. Staff in this center will contact selected families with EPSDT-eligible children (those who have newly enrolled in the program or who have recently had that eligibility re-verified) and offer information and assistance with scheduling appointments.
- Working with the dental benefits manager, Doral Dental, to develop and distribute oral health educational materials to members eligible for dental screenings. Doral Dental has developed a postcard campaign, with telephone follow-up, targeting members ages 3 and 13 to 19 who have not received a dental service. The dental benefits manager also provides information on dental services to childcare centers and Headstart programs. They also target new and expectant mothers by displaying booths at community baby showers and conferences.
- Working with Doral Dental to target teens and "at-risk" populations for oral health. Doral Dental has developed an oral health project aimed at high school students that includes surveys to assess oral health care habits, the distribution of oral health packets, presentations to youth groups, and the development of educational materials on dental careers. Doral Dental also attempts to limit the disparities in access to dental care by focusing on "at risk" populations by translating educational materials into other languages, using audiotape educational materials for the visually impaired, and providing care coordination to help DCS children access oral health services.
- Monitoring the provision of outreach to children receiving services through the School-Based Dental Prevention Project. The Department of Health provides preventive dental services to children in target schools (schools with more than 50 percent of children receiving free and reduced lunches). The forms used to report the

results of the school-based dental screenings encourage parents of TennCare children to seek EPSDT screenings for their children.

- Evaluating the quality of educational materials, the breadth of outreach campaigns and the extent to which the campaigns achieve their objectives of increasing awareness of the importance of screenings. Results of the evaluations will be used to improve materials, refine the core message if needed, and identify new opportunities for outreach.

The outreach strategies outlined above will likely contribute to enhanced screening percentages in the following ways:

- The implementation of a clear, consistent message about EPSDT will help eliminate the confusing and sometimes contradictory messages families hear about the EPDST program. The new “brand name” for EPSDT will encourage parents to inquire about TENNderCARE/TeenCare, and the associated screenings. Widespread acceptance of the EPSDT program over time will increase the number of children receiving screens and, in turn, the APSP and DSP. The outreach campaign is specifically designed to provide the information that parents, children, and adolescents need to support their decisions to seek well-child care in a timely fashion.
- The implementation of a standardized training module through the train-the-trainer strategy will provide consistent guidance on EPSDT requirements and protocols and ensure the dissemination of accurate information. When fully informed about EPSDT, the trainers may increase the numbers of children being screened by informing TennCare families about EPSDT and assisting with scheduling or transportation, all of which can improve screening percentages.
- Increasing contact with families regarding appointments should also improve screening percentages.

### **3. Current Schedule**

Figure III.1 presents the current schedule for activities underway or planned by the Enrollee Outreach workgroup for each quarter through the end of 2005. As the workgroup continues to meet, this schedule will evolve in light of new ideas and opportunities, and in response to evaluative data indicating the extent to which the educational materials and outreach activities are being used and received in the intended manner.

FIGURE III.1

CURRENT SCHEDULE OF ACTIVITIES UNDERWAY OR PLANNED  
BY THE ENROLLEE OUTREACH WORKGROUP

|  | 2 <sup>nd</sup><br>Quarter<br>2004 | 3 <sup>rd</sup><br>Quarter<br>2004 | 4 <sup>th</sup><br>Quarter<br>2004 | 1 <sup>st</sup><br>Quarter<br>2005 | 2 <sup>nd</sup><br>Quarter<br>2005 | 3 <sup>rd</sup><br>Quarter<br>2005 | 4 <sup>th</sup><br>Quarter<br>2005 |
|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Initiating efforts to promote new name and logo            |                                    |                                    |                                    |                                    |                                    |                                    |                                    |
| Revising content for special populations                   |                                    |                                    |                                    |                                    |                                    |                                    |                                    |
| Implementing train-the-trainer sessions                    |                                    |                                    |                                    |                                    |                                    |                                    |                                    |
| Tracking DOH's Outreach Campaign                           |                                    |                                    |                                    |                                    |                                    |                                    |                                    |
| Tracking implementation of DOH's Outreach Call Center      |                                    |                                    |                                    |                                    |                                    |                                    |                                    |
| Conducting oral health outreach                            | TBD                                |                                    |                                    |                                    |                                    |                                    |                                    |
| Working with Doral Dental to develop, distribute materials | TBD                                |                                    |                                    |                                    |                                    |                                    |                                    |
| Monitoring outreach provided in school-based project       |                                    |                                    |                                    |                                    |                                    |                                    |                                    |
| Evaluation activities related to outreach activities       |                                    |                                    |                                    |                                    |                                    |                                    |                                    |

NOTE: This schedule of activities will be further developed and refined by the workgroup as it continues to meet. Many of the activities are in the planning stage at the present time.

TBD = To be determined.

## B. PROVIDER EDUCATION AND PARTICIPATION

### 1. Influential Factors

Despite extensive efforts by the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) and the state, some pediatricians or family practitioners in Tennessee may be unfamiliar with the specific screenings required under the state's EPSDT program or may believe that certain screenings are unnecessary for children of certain ages. In addition, some providers may be unaware that they can be reimbursed for both a sick visit and a well-child visit if screenings are provided to a child as part of a visit that was initiated because the child was sick. Consequently, physicians may not provide screenings or, if they do provide the screenings,

may not submit related procedure codes on billing forms. The reluctance or failure of PCPs to provide or document the delivery of ESPDT screens is a specific case of a broader concern. In general, physicians may not practice in accordance with evidence-based guidelines because they may not know about these guidelines or disagree with them (Cabana et al. 1999). Furthermore, physicians may not follow specific recommended guidelines for children's health because few have been rigorously evaluated in terms of their capacity to improve health outcomes (Cabana and Flores 2002).

Also, small clinical practices may lack support for quality of care improvements and may not have the operational capacity to make changes in their practice patterns or record-keeping procedures, such as implementing electronic medical records or re-designing patient flow to use time more productively (Leatherman and McCarthy 2004). Many PCPs may have neither the technical means nor back-up support to participate in educational programs offered, for example, through interactive, web-based venues. According to a report provided by the TennCare's Division of Quality Oversight, in 2002, 31 percent of 231 surveyed providers did not have a system of contacting TennCare enrollees who missed an appointment and 37 percent did not have a system for reminding patients about EPSDT visits. The absence of these procedures may limit the percent of well-child appointments that are kept. In Tennessee the MCO, not the provider, is officially charged with the responsibility for contacting patients who are behind on their screens. However, providers carry out many of these efforts. The Provider Education and Participation workgroup will address these issues.

## **2. Specific Activities**

The Provider Education and Participation workgroup includes representatives from the TNAAP, with whom TennCare currently has a contract for provider education activities, and staff from other key departments. One goal of the workgroup is to support the provider

community with educational programs about EPSDT. Activities underway or planned to enhance knowledge about screening procedures for EPSDT include the following:

- Continuing current provider education activities. As part of its contract with TennCare, TNAAP presently conducts activities to educate providers about the importance of EPSDT procedures including screening guidelines, coding procedures and billing. TNAAP conducts site visits to providers and is in the process of developing an educational effort that will focus on screening instruments, documentation, reimbursement policies, and referrals.
- Continuing provider education activities for dental services. Doral Dental schedules annual provider training sessions that include a review of EPSDT. Upon request, Doral Dental representatives also visit participating dental offices to personally train appropriate staff members. Newsletters are mailed quarterly addressing EPSDT-related issues and education materials are available on Doral Dental's website.
- Building on TNAAP's current activities and strengthening education efforts. The Provider Education and Participation workgroup will develop a sustainable, multifaceted campaign to enhance provider support for and participation in the EPSDT program, including revising the TennCare provider video to incorporate the new screening guidelines and outreach campaign.

These strategies will likely contribute to improved screening percentages over time because more screenings will include all components and will be recorded accurately.

The Provider Education and Participation workgroup is also focused on developing methods to assess adequacy of Medicaid PCP networks using diverse sources of data. While the workgroup will consider new methods of assessment, activities currently underway or planned to assure network adequacy and enhance access to and availability of PCPs include the following:

- Conducting a telephone survey with all PCPs in the state. This survey will include both participating and non-participating physicians, and will gather information on reasons for participation or non-participation, panel status, key office procedures, and EPSDT screening data.
- Expanding the dental provider network. Doral Dental contacts all offices annually to confirm providers are continuing to treat TennCare patients, verify their status and validate location information. They also make random survey calls quarterly to question staff in participating offices if the provider is currently treating TennCare patients and about appointment availability. Further, to improve access to EPSDT dental services, the state has implemented initiatives such as increasing the



reimbursement level for dentists, awarding dental special needs grants to counties, administering three mobile dental clinics in rural regions, and launching school-based dental prevention services statewide.

The activities described above are likely to contribute to enhanced screening percentages over time for the following reasons:

- Improvements in methods for assessing network adequacy, such as the provider survey, will allow the state to target deficient areas. Information from the provider survey regarding why providers choose not to participate in TennCare will be particularly helpful in determining strategies to improve participation.
- Assuring adequacy (i.e., the number of participating providers and the number of TennCare children each provider is willing to accept) should eventually lead to greater access and availability of PCPs and dental providers.

One of the biggest challenges facing Tennessee is developing reliable information on whether children have received all required screens. The Provider Education and Participation workgroup will work to expand existing efforts to develop a standard approach. This will include the following:

- Further dissemination of current EPSDT forms, developed by TNAAP
- Integrating these forms with those used by Department of Health clinics
- Working with other sub groups to enhance the data collection system

Tennessee is one of the few states where the local American Academy of Pediatrics (AAP) chapter has been working for several years to develop and disseminate a standard EPSDT form and where the public health clinics are using a standard EPSDT form. In neither case is information on these forms entered into a database that could be used to generate accurate estimates of the delivery of EPSDT screens. Eventually, it will be important to develop a way to collect information about the delivery of these screens in a standard fashion, to enter this information into a user-friendly database, and to determine how such information could be used






to monitor the EPSDT program and possibly to provide clinically useful data back to the physician. As it continues to meet, the workgroup may elect to address this issue.

### 3. Current Schedule

This workgroup had its first formal meeting in April 2004, and hence is early in the development of schedule specifications. Figure III.2 presents the current version of the schedule of activities, but the schedule will be expanded and refined as the workgroup continues to meet.

FIGURE III.2

CURRENT SCHEDULE OF ACTIVITIES UNDERWAY OR PLANNED BY  
THE PROVIDER EDUCATION AND PARTICIPATION WORKGROUP

|   | 2 <sup>nd</sup><br>Quarter<br>2004   | 3 <sup>rd</sup><br>Quarter<br>2004  | 4 <sup>th</sup><br>Quarter<br>2004 | 1 <sup>st</sup><br>Quarter<br>2005 | 2 <sup>nd</sup><br>Quarter<br>2005 | 3 <sup>rd</sup><br>Quarter<br>2005 | 4 <sup>th</sup><br>Quarter<br>2005 |
|---|--|---|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Continuing current provider education activities (through TNAAP)                            |  |   |                                    |                                    |                                    |                                    |                                    |
| Continuing current provider education activities for dental services (through Doral Dental) |  |   |                                    |                                    |                                    |                                    |                                    |
| Developing campaign to build support for EPSDT among providers                              |   |   |                                    |                                    |                                    |                                    |                                    |
| Conducting telephone survey with all PCPs in the state                                      |  |  |                                    |                                    |                                    |                                    |                                    |
| Using GeoAccess mapping capabilities  |  |   |                                    |                                    |                                    |                                    |                                    |
| Expanding the dental provider network   | TBD  |   |                                    |                                    |                                    |                                    |                                    |
| Developing a standard approach for determining if children have received screens            | TBD  |   |                                    |                                    |                                    |                                    |                                    |

NOTE: This schedule of activities will be further developed and refined by the workgroup as it continues to meet. Many of the activities are in the planning stage at the present time.

TBD = To be determined.

## **C. SCREENING DATA**

### **1. Influential Factors**

Data collection, coding, and analysis procedures can affect the calculation of screening percentages. Inaccuracies in data gathering may lead to unreliable percentages because EPSDT well-child visits have been over- or undercounted. Percentages of children who received complete EPSDT screens cannot be calculated with the use of federally required procedure codes because these codes do not identify each specific component of an EPSDT screen. Furthermore, substantial debate can arise regarding the specific algorithms or methods used in the calculations.

**Data Gathering Issues.** Numerous problems can emerge in gathering data needed for accurate calculation of screening percentages. A child may receive different components of an EPSDT well-child visit from different sites or providers or from the same provider at different times. For example, a child may be immunized at a local health department and receive other required screens from a PCP within the same week. Or, a child may visit a PCP for an ear-infection and the PCP takes the opportunity to provide all of the required components of a comprehensive EPSDT well-child visit except immunizations; the PCP then provides the immunizations at a two-week follow-up visit after the ear infection has resolved.

In these examples, the child has actually received all of the EPSDT well-child components, but this outcome may not be reflected in the data gathering procedures. A medical chart review might not reveal that all components of the well-child visit were completed. In the first case, the PCP may not have indicated in the chart that the child received immunizations elsewhere. In the second case, the chart review could occur between the first and second visit, in which case the child would not be counted as having a complete screen when in fact he or she did. Furthermore, some PCPs perform examinations using observation or indirect methods that may not be easily documented. For example, a PCP may observe a child's response to sounds during an

examination and conclude the child does not have hearing problems. The PCP does not perform an objective hearing screening and, therefore, may not document that a hearing check was conducted.

In Tennessee, a continuing problem involves identifying well-child visits for newborns. Most infants receive their initial EPSDT-related screens before discharge from the hospital but these are not captured because the service is billed under the mother's TennCare identification number. As a result, the number of well-child visits for children under 1 year of age is probably undercounted.

**Data Coding Issues.** The CMS instructions for Form 416 specify which diagnostic and procedure codes should be used to define a well-child visit. However, these codes are not fully consistent with EPSDT-related screening methods and hence do not accurately signal whether the provider completed all of the required screens.

For example, a pediatrician can conduct what he or she considers to be an adequate and comprehensive well-child exam and mark the code for this exam on the claim form, even though the exam may not have included all of the required components as specified in the EPSDT regulations. The codes included in the instructions are the best proxies currently available for indicating EPSDT-related screenings, but they are limited because they do not reflect the number of specific EPSDT screens that the physician actually provides.

**Analysis Issues.** Issues related to data analysis that can influence reported screening percentages include the following:

- Changes in how percentages are calculated may make year-to-year comparisons unreliable; these changes may result from policy changes or from discoveries of previously unrecognized errors in mathematical formulas
- Policy makers, program staff, and researchers may disagree on what algorithms should be used to calculate screening percentages

- Data from different sites may not be able to be merged within a single file with individual data, thus preventing an analysis of whether children received all screens
- Attempts to correct known deficiencies in the Form 416 data may introduce other problems. For example, in Tennessee, the sample of children drawn for the record review that is used to adjust the Form 416 figures may not match the population of children who are included in the data used for Form 416 figures data, leading to an inaccurate adjusted figure.

## 2. Specific Activities

The Screening Data workgroup will convene in May 2004 to address the issues identified above.<sup>10</sup> The activities of this workgroup will include the following:

- Working closely with the Provider Education and Participation workgroup to develop the system for entry and analysis of information on the delivery of specific screens using a standard form. This long-term task involves identifying a data platform, determining realistic methods for data entry, and developing support for a comprehensive system. The workgroup may invite experts in data management systems to help in this effort.
- Integrating the EPSDT forms used in public health clinics with the TNAAP forms. All local health department clinics in Tennessee now use a standard EPSDT screening procedure and documentation form for all Medicaid children, including children in state custody. TNAAP also encourages PCPs to use a standard form. The workgroup will develop recommendations for integrating these two sources of information as part of the process for building a stronger data collection system.
- Reviewing possible strategies for building on current methods for calculating and projecting changes in performance measures, such as the APSP and DSP, by modeling changes in age-specific screening percentages.
- Developing recommendations for additional performance measures that will assist program directors in monitoring progress toward improved screening percentages. Such measures may include, for example, age-specific indices of appointment making and keeping or measures of “outbreaks” of decreased screening percentages.
- Developing recommendations for using the External Quality Review Organization (EQRO) to improve the monitoring capacity of MCOs. The state’s EQRO performs an independent annual review of network adequacy and will use a new survey tool for the 2004 survey. The new tool focuses on performance measures to enable TennCare

---

<sup>10</sup> Although not relevant to this report on screening percentages, the workgroup will also address issues related to tracking referrals of children identified as needing evaluation or treatment.

to identify any deficiencies that require corrective action plans and includes special sections on network adequacy and EPSDT. The workgroup will consider performance strategies that could be used by the EQRO to enhance the role of MCOs in improving screening percentages.

- Developing specific recommendations for using data from the Consumer Assessment of Health Plan Survey (CAHPS) if this survey is used in the future. Through the CAHPS, the state could have access to consumers' ratings of the quality of care and services they receive from health plans and would be able to assess access and network adequacy from the enrollee's point of view. Analysis of these data could assist the Enrollee Outreach workgroup to refine outreach strategies.

Overall, these activities will contribute to more information and increasingly accurate data with which to track screening procedures and factors that influence screening percentages. The diverse sources of information—including data on provider behavior, enrollee perspectives, and MCO performance—should increase substantially the capacity of program leadership to take the steps needed to improve screening percentages.

### **3. Current Schedule**

This workgroup was formally appointed in April 2004 and will have its first formal meeting in May 2004. Hence, the schedule noted in Figure III.3 should be viewed as a very early and tentative indication of the workgroup's schedule of activities. The schedule will be expanded and refined as the workgroup begins meeting.

## **D. PROGRAM MONITORING AND COORDINATION**

### **1. Influential Factors**

Virtually all states face major challenges in implementing the EPSDT program. First, the EPSDT program is inherently complex. An effective program requires a staff with multiple skills, including program marketing, provider education, quality-of-care oversight, data collection and analysis, contract development and monitoring, and coordinating activities with

other state agencies involved in providing EPSDT services. This is a complex set of skills and few state EPSDT programs have a staff that is equally strong in all of these areas.

FIGURE III.3

CURRENT SCHEDULE OF ACTIVITIES UNDERWAY OR PLANNED  
BY THE SCREENING DATA WORKGROUP

|   | 2 <sup>nd</sup><br>Quarter<br>2004 | 3 <sup>rd</sup><br>Quarter<br>2004 | 4 <sup>th</sup><br>Quarter<br>2004 | 1 <sup>st</sup><br>Quarter<br>2005 | 2 <sup>nd</sup><br>Quarter<br>2005 | 3 <sup>rd</sup><br>Quarter<br>2005 | 4 <sup>th</sup><br>Quarter<br>2005 |
|---|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Refine objectives and develop specific schedule                             | ■                                  |                                    |                                    |                                    |                                    |                                    |                                    |
| Develop system for entry and analysis of screening data using standard form |                                    |                                    | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  |
| Integrate EPSDT forms used in public health clinics with TNAAP forms        |                                    | ■                                  | ■                                  | ■                                  | ■                                  |                                    |                                    |
| Model changes in age-specific screening percentages                         |                                    | ■                                  | ■                                  | ■                                  |                                    |                                    |                                    |
| Develop recommendations for additional performance measures                 |                                    |                                    |                                    | ■                                  | ■                                  |                                    |                                    |
| Develop recommendations for using the EQRO to improve monitoring of MCOs    |                                    | ■                                  | ■                                  | ■                                  |                                    | ■                                  | ■                                  |
| Develop recommendations for using data from CAHPS                           |                                    | ■                                  | ■                                  | ■                                  |                                    | ■                                  | ■                                  |

NOTE: This schedule of activities will be further developed and refined by the workgroup as it continues to meet. Many of the activities are in the very early planning stage at the present time.

Second, the field lacks a set of “best practices” that states can adopt to improve their programs. We know of no studies that have compared the organizational structure or management practices of multiple state EPSDT programs. Few well-accepted organizational measures or standards (for example, the number of central staff needed to operate an EPSDT program for a given number of children) are available to assess a state’s program relative to programs in other states. Although

individual states have commissioned reports on their EPSDT programs,<sup>11</sup> these reports tend to focus on state-specific issues or use state-specific data that preclude between-state comparisons.

Third, national data on the performance of state EPSDT programs are unreliable. In a July 2001 report to Congress, the General Accounting Office noted “Despite statutory reporting requirements, reliable national data are not available on the extent to which children in Medicaid are receiving EPSDT services” (GAO 2001, p. 9). Overall, the absence of a comprehensive foundation of knowledge about effective practices for an EPSDT program and the inadequate national performance data limits any single state’s capacity to assess fully how its program is functioning in relation to programs in other states.

Fourth, most states lack the well-integrated, comprehensive system of child health services and diverse, accessible provider networks that, in an ideal world, would support an EPSDT program. In Tennessee, for example, the absence of mental health providers in many rural areas poses substantial problems for ensuring the availability of adequate mental health diagnostic and treatment services. In addition, according to some pediatricians, Medicaid-enrolled children in certain areas of the state have fewer choices for office-based pediatric care compared to other areas because some providers do not accept or limit the number of low-income children in their practices. Public health clinics, however, do provide access to screening services in these areas.

Finally, over the last several decades, federal and state support for child health care programs has been uneven. Child health programs generally have been under-funded in many states, and the EPSDT program is no exception. Most states have not focused extensive financial and staff resources on implementing the EPSDT program, in part because other health issues

---

<sup>11</sup>See, for example: Michigan Council for Maternal and Child Health. “EPSDT: Early Periodic Screening Detection and Treatment: A Snapshot of Service Utilization by Health Plan for 1999.” Spring 2002.



have claimed the attention of state Medicaid and health agencies. Moreover, recent policy efforts have focused on increasing the number of low-income children who have some insurance coverage, rather than increasing efforts to provide a particular set of services to children already enrolled in Medicaid.

Tennessee, like many states, is facing sharp constraints in its Medicaid budget. Additional resources for strengthening the EPSDT program are likely to emerge from increasing administrative efficiency and re-allocation of current resources, rather than from a major infusion of new dollars or staff.

## **2. Specific Activities**

These issues and challenges underscore the importance of a strong management structure to assure that all of the workgroups' activities are coordinated and contribute in a cohesive manner to improving screening percentages. The Program Monitoring and Coordination workgroup will provide this structure and work to develop effective management tools that will assist this workgroup to monitor other workgroup activities (and its own) and to track progress toward short and long-term objectives related to screening percentages.<sup>12</sup> The following specific activities are currently underway or planned (additional ones will be identified when the workgroup is formally established):

- Developing measurement tools to track the activities of each workgroup and identify new or emerging issues. A spreadsheet has been created to document workgroup activities includes objectives, tasks, measurement standards, and expected completion dates.

---

<sup>12</sup>As noted in Table I.1, this workgroup has not been established formally. In lieu of designated committee members, MPR and selected staff from the Governor's Office and TennCare have been working closely together to monitor and coordinate workgroups since January 2004. These individuals will continue to serve in this capacity until a Program Monitoring and Coordination workgroup is established.

- Identifying experts that can assist specific workgroups and making recommendations for how selected experts can contribute to workgroup activities. For example, a group of individuals at Georgetown University have developed interactive web-based provider education tools related to the EPSDT program. The Provider Education and Participation workgroup may wish to meet with these individuals to help develop similar programs in Tennessee.
- Monitoring the implementation of a new TennCare Management Information System (TCMIS) and determining its utility for the EPSDT program. The TCMIS, for example, includes a letter generator that can automatically send letters to the child/family to notify them when they are due or overdue for EPSDT screens. The system also will include the periodicity schedule to show when a child should receive the appropriate immunizations and will be updated by providers, health departments and MCOs. TCMIS will allow TennCare to share EPSDT reports with other agencies and generate numerous reports including reports on providers eligible to perform EPSDT screens and reports relating to DCS children.
- Developing recommendations for staff to operate a central EPSDT office that may be placed in the Governor's Office and will assume monitoring and coordination activities. Positions for this staff have been requested and, if approved, the staff will be hired in the summer or early fall of 2004.
- Creating a set of indices for senior management review that documents problems in network adequacy, provider participation, and data management. The set of indicators will allow senior management to develop rapid assessments of workgroup activities and overall program progress.
- Supporting collaboration among departments and between departments and other organizations. For example, Doral Dental is collaborating with the Department of Health, professional organizations, and community groups to make presentations to groups about EPSDT dental services, display information at health events, and provide oral health supplies. This workgroup will assist in identifying other opportunities for collaboration.
- Reviewing reports from MCOs and other contractors through the Office of Contract Development and Compliance to ensure that contract provisions are being met
- Providing information to commissioners of key departments for meetings to help coordinate EPSDT services across departments
- Developing an overall schedule that will allow the tracking of specific activities linked to each workgroup
- Convening monthly meetings of the chairs of each workgroup to coordinate activities across workgroups

Overall, these activities will contribute to the enhancement of screening percentages by allowing program leadership to track workgroup activities efficiently and effectively, identify

progress and potential problems, discuss these problems at the appropriate level, and develop solutions as quickly as possible.

### 3. Current Schedule

The Program Monitoring and Coordination workgroup has not been formally appointed yet, but activities have been underway since January 2004. The schedule noted in Figure III.4 should be viewed as a very early and tentative indication of the workgroup's schedule of activities. This schedule will be expanded and refined as the workgroup begins meeting.

FIGURE III.4

CURRENT SCHEDULE OF ACTIVITIES UNDERWAY OR PLANNED  
BY THE PROGRAM MONITORING AND COORDINATION WORKGROUP

|  | 2 <sup>nd</sup><br>Quarter<br>2004 | 3 <sup>rd</sup><br>Quarter<br>2004 | 4 <sup>th</sup><br>Quarter<br>2004 | 1 <sup>st</sup><br>Quarter<br>2005 | 2 <sup>nd</sup><br>Quarter<br>2005 | 3 <sup>rd</sup><br>Quarter<br>2005 | 4 <sup>th</sup><br>Quarter<br>2005 |
|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Developing measurement tools                                 | ■                                  | ■                                  |                                    |                                    |                                    |                                    |                                    |
| Identifying experts that can assist workgroups               | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  |
| Monitoring the implementation of TCMIS                       | ■                                  | ■                                  | ■                                  |                                    |                                    |                                    |                                    |
| Developing recommendations for central EPSDT office          | ■                                  | ■                                  |                                    |                                    |                                    |                                    |                                    |
| Creating indices for senior management review                | ■                                  | ■                                  |                                    |                                    |                                    |                                    |                                    |
| Supporting collaboration among departments                   | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  |
| Ensuring contract provisions are being met                   | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  |
| Providing information to commissioners for meeting           | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  |
| Developing an overall schedule to track workgroup activities | ■                                  | ■                                  |                                    |                                    |                                    |                                    |                                    |
| Convening monthly meetings of each workgroup chair           |                                    | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  | ■                                  |

NOTE: This schedule of activities will be further developed and refined by the workgroup when it is formally established. Many of the activities are in the very early planning stage at the present time.

#### **IV. SUMMARY**

Our analyses suggest that if the screening percentage (as indicated on the CMS Form 416) continues to grow at current rates and if the screening completion rate (as determined by on-site medical record reviews) grows by at least 5 percent each year, then the APSP could reach 80 by 2009. If the DSP grows by 10 percent each year, then our projections suggest that it will reach 85 in 2011.

These projections are necessarily conditional on the many factors that affect the APSP and DSP, including factors that influence parental and adolescent decision-making with regards to well-child and dental care, availability and accessibility of primary care providers and opportunities for dental screening, provider knowledge and capacity, and changes in methods of data collection and analysis. The number and complexity of these factors make it extremely challenging to predict when the state will attain a specific APSP or DSP objective.

Any single index of the performance of a public health program as multi-faceted as the EPSDT program will fail to capture important program components. Relying on a single figure, such as the APSP or the DSP, will be insufficient to manage program growth and functioning. Instead, a broad array of measures and indices are needed to track progress toward specific objectives. For example, tracking the extent to which the outreach campaign is successful in reaching each age group will help in understanding differences in rates of well-child visits across different ages. It will be important to focus on increasing the percentage of eligible adolescents who receive health and dental screenings because this percentage is low relative to other age groups and the attainment of a particular overall objective may be limited by the difficulties in increasing adolescent screening rates. Developing realistic gradients for increasing screening

percentages for each age group for each year would help focus activities and establish attainable goals.

## REFERENCES

- Agency for Healthcare Research and Quality. "Statistical Brief #3: Children's Health Care Quality, Fall 2000." Washington, DC: U.S. Department of Health and Human Services, 2002.
- Cabana, M.D., et al. "Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement." *Journal of the American Medical Association*, 282, 1999, pp. 1458-1465.
- Cabana, M.D. and G. Flores. "The Role of Clinical Practice Guidelines in Enhancing Quality and Reducing Racial/Ethnic Disparities in Pediatrics." *Pediatric Respiratory Review*, 3, pp. 52-58.
- Ireys, Henry, Tara Krissik and Margo Rosenbach. *Independent Assessment of Tennessee's EPSDT Program and an Action Plan for Measuring Progress in Achieving Program Goals*. Washington, DC: Mathematica Policy Research, Inc. December 2003.
- Leatherman, Sheila and Douglas McCarthy. *Quality of Health Care for Children and Adolescents: A Chartbook*. New York, NY: The Commonwealth Fund. April 2004.
- U.S. General Accounting Office. *Medicaid: Stronger Efforts Needed to Ensure Children's Access To Health Screening Services*. Washington, DC: GAO, July 2001 (GAO-01-749).
- Yu, S.M. et al. "Factors That Influence Receipt of Recommended Preventive Pediatric Health and Dental Care." *Pediatrics*, 110, 2002, p. E73.